WZ052



*Class*_____ *No.*_____

Gift.

Bdg.3.25

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofkentuck5419kent

STACKS

FEB 16 1956

OF PHILADELPHIA

The Journal

OF THE KENTUCKY STATE MEDICAL ASSOCIATION

VOL. 54 JANUARY, 1956 NO. 1

Contents

SCIENTIFIC ARTICLES

FIRE AND EXPLOSION HAZARDS WITH FLAMMABLE ANESTHETIC AGENTS AND THEIR CONTROL, George J. Thomas, M. D. 27

THE INDICATED STATUS OF THROMBO-ENDARTERECTOMY, John B. Floyd, Jr., M. D. 33

HEART DISEASE IN PREGNANCY, C. Brinley Bland, M. D., F.A.C.S. 36

USE OF TRYPSIN IN INFLAMMATION, Bert Seligman, M. D. 43

FLUID AND ELECTROLYTE BALANCE IN RENAL DISEASE, Stanley G. Doll, M. D. 47

CASE DISCUSSIONS 51

SOCIAL SECURITY—BIG ISSUE IN 1956 55

DIGEST OF PROCEEDINGS OF THE 1955 ANNUAL MEETING 56

EDITORIALS

HERNIA IN INFANTS AND CHILDREN 67

THE ACUTE DUODENAL ULCER 68

ORGANIZATION SECTION

Society Officers to Meet March 29 69

Dr. Hess Speaks at Clinical Meet 69

RH Conference is January 19, 1956 69

Pa. Physician is GP of the Year 70

'56 Meet to Have 2 Specialty Groups 70

11 Ky. Surgeons Named ACS Fellows 70

Post Grad Medical Education Discussed 70

Blue Shield Group Re-elects Dr. Pierce 71

AMA Delegates Act on HR 7225, OASI 71

13 Ky. MD's Attend Clinical Meeting 72

Senior Day Committee Announced 72

Ky. Well Represented at SMA Meeting 72

REGULAR DEPARTMENTS

President's Page 8, In the Books 12, Washington News Digest 18, News Items 78, Pertinent Paragraphs 79, County Society Reports 80, In Memorian 81

1956 Constitution and By-Laws of the Kentucky State Medical Association 82



new vistas

for the . . . .

Effective control of seizures, social acceptance, and recognition of employment potential are providing new vistas for the majority of epileptic patients. Accurate diagnosis and adequate therapy, as in present-day management, can be expected more confidently than ever before to restore such patients to as full a life as is compatible with their condition.

DILANTIN® SODIUM

(diphenylhydantoin sodium, Parke-Davis)

Alone or in combination, DILANTIN continues as an anticonvulsant of choice for control of grand mal and of psychomotor seizures. In addition to its notable effectiveness, DILANTIN has little or no hypnotic effect.

DILANTIN Sodium is supplied in a variety of forms—including Kapseals® of 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) in bottles of 100 and 1,000.



MEDICAMENTA VERA

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

The JOURNAL of the

Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR: BRUCE UNDERWOOD, M. D. — MED. EDITORIAL EDITOR: S. A. OVERSTREET, M.D.
MANAGING EDITOR: J. P. SANFORD — BOOK REVIEW EDITOR: WALTER S. COE, M.D.
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D. — ORGANIZATION EDITOR: BARBARA N. MORGAN
CASE DISCUSSIONS EDITOR: J. C. BELL, M.D. — PUBLISHER: J. G. DENHARDT, BOWLING GREEN

ADVISORY COMMITTEE TO THE EDITOR

Richard J. Rust, M. D. — Guy Aud, M. D., Chairman — James E. Hix, M. D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1958	Term Expires July 1, 1957	Term Expires July 1, 1956
Henry B. Asman, M.D.	Carey C. Barrett, M.D.	Everett H. Baker, M.D.
Richard Elliott, M.D.	Joe Bush, M.D.	John L. Dixon, M.D.
Rankin Blount, M.D.	Allen E. Grimes, M.D.	George G. Greene, M.D.
Marion F. Beard, M.D.	Richard F. Grise, M.D.	R. Arnold Griswold, M.D.
Glenn Bryant, M.D.	Billy Keller, M.D.	O. Leon Higdon, M.D.
Douglas Scott, M.D.	A. J. Miller, M.D.	James M. Keeton, M.D.
William C. Buschemeyer, M.D.	Robert Reeves, M.D.	Frank Moore, M.D.
Harry D. Abell, M.D.	Charles R. Yancey, M.D.	Alvin C. Poweleit, M.D.

Editorial and Business Offices, 620 S. Third St., Louisville, Kentucky

Subscription $8.00 per year — Single Copy .80

KENTUCKY STATE MEDICAL ASSOCIATION OFFICERS—1955-56

Gant Gaither, 109½ East 7th Street, Hopkinsville ..... President
Richard R. Slucher, Buechel ..... President-Elect
Clyde C. Sparks, M.D., Mayo Arcade Ashland ..... Immediate Past President
Everett Baker, 408 Brown Bldg., Louisville ..... Vice-President
Nathaniel Bosworth, 117 S. Ashland, Lexington ..... Vice-President
Howell J. Davis, 330½ Allen, Owensboro ..... Vice-President
Bruce Underwood, 620 S. Third St., Louisville ..... Secretary-Editor
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Treasurer
Charles A. Vance, 271 W. Short Street, Lexington ..... Speaker—House of Delegates
E. W. Jackson, 333 Broadway, Paducah ..... Vice Speaker—House of Delegates
J. Vernon Pace, 709-10 Citizen's Bank Bldg., Paducah ..... Chairman of the Council
Delmas M. Clardy, Hopkinsville ..... Vice-Chairman of the Council

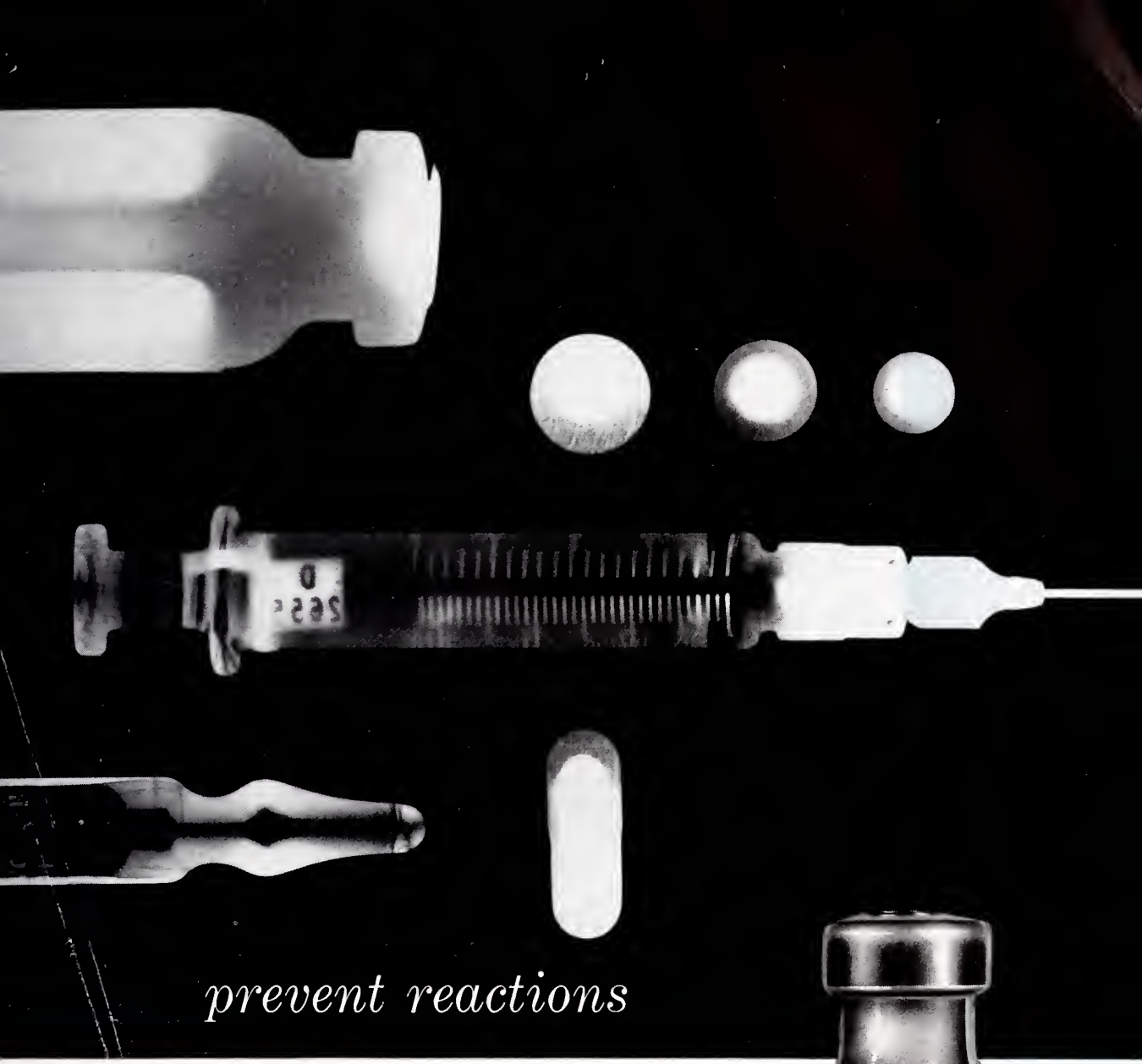
DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan	1956
David M. Cox, 102 Breckenridge Lane, Louisville, (Alternate)	1956
W. Vinson Pierce, 33 E. Seventh St., Covington	1957
Leon Higdon, 333 Broadway, Paducah, (Alternate)	1957

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Building, Paducah	1956
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1958
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Carlisle Morse, 3612 Lexington Road, Louisville	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1958
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1957
Ninth District	J. M. Stevenson, Brookville	1958
Tenth District	J. Farra Van Meter, 183 N. Upper Street, Lexington	1958
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1958
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Charles B. Stacy, Pineville	1957

Entered as second-class matter, Oct. 22, 1906, at the Post Office at Bowling Green, Ky., under act of Congress, Mar. 3, 1897. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.



prevent reactions



To safeguard your patients add 1 cc. of CHLOR-TRIMETON Injection 100 mg./cc. to each 10 cc. vial of aqueous penicillin.

Supplied: 2 cc. multiple-dose vial. For intramuscular and subcutaneous administration.

CHLOR-TRIMETON® maleate, brand of chlorprophenpyridamine maleate.

CT-J-88

Yes, you can have Real Tobacco Taste in a Filter Cigarette!



The VICEROY filter tip contains 20,000 tiny filters made exclusively from pure, white cellulose. This is twice as many as the next two largest-selling filter brands.

No wonder VICEROY gives you that fresh, clean, real tobacco taste you miss in other filter brands. No wonder so many doctors now smoke and recommend King-Size VICEROYS.



NOW IN TWO POTENCIES

for more precise dosage

NEW  1 mg. *pink* tablet |  5 mg. tablet

MOST POTENT ANTI-RHEUMATIC

Sterane*

Both tablets are deep-scored and of the **SAME DISTINCTIVE "FINGER-GRIP" SIZE AND SHAPE** for ease of handling and breaking by arthritic fingers.

anti-rheumatic/anti-allergic/anti-inflammatory

supplied: **Pink,** 1 mg. oral tablets, bottles of 100.
White, 5 mg. oral tablets, bottles of 20 and 100.

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

*brand of prednisolone

President's Page

Austin Smith, M. D., delightful speaker and editor of the Journal of the AMA, recently made clear what has happened in several of the countries in Europe where state medicine has taken over.

The bureaus, the labor unions and the great industrial concerns working with various governmental agencies have to authorize the purchase of expensive biochemicals before they can be given. They determine to which hospital a patient must go and assign him his physician. We find ourselves relegated to be 'technicians' in their schedule.

One of the answers to this, it seems to me, is rapid nationalization of both BLUE CROSS and BLUE SHIELD. Then we shall have to make these, in ten years, more or less, the focal points with whom all bargaining for medical and hospital care can be made. How this shall be done must be worked out as the thing develops.

But with enormously powerful welfare and health funds yearly springing into being—launching their various activities *with our help*—into the field of supplying medical and hospital care, we may find that the enormous labor groups in a decade will all be purchasing these cares with their own funds. Our free patronage area will be shrinking.

It may require some unusual measures to recoup our lost position. We must keep our position strong—get BLUE CROSS and BLUE SHIELD in national organizations with every physician in the United States heartily enrolled as a subscriber to its programs—and no deviation.

This battle is shaping up. Think it through.

Grant Gaither

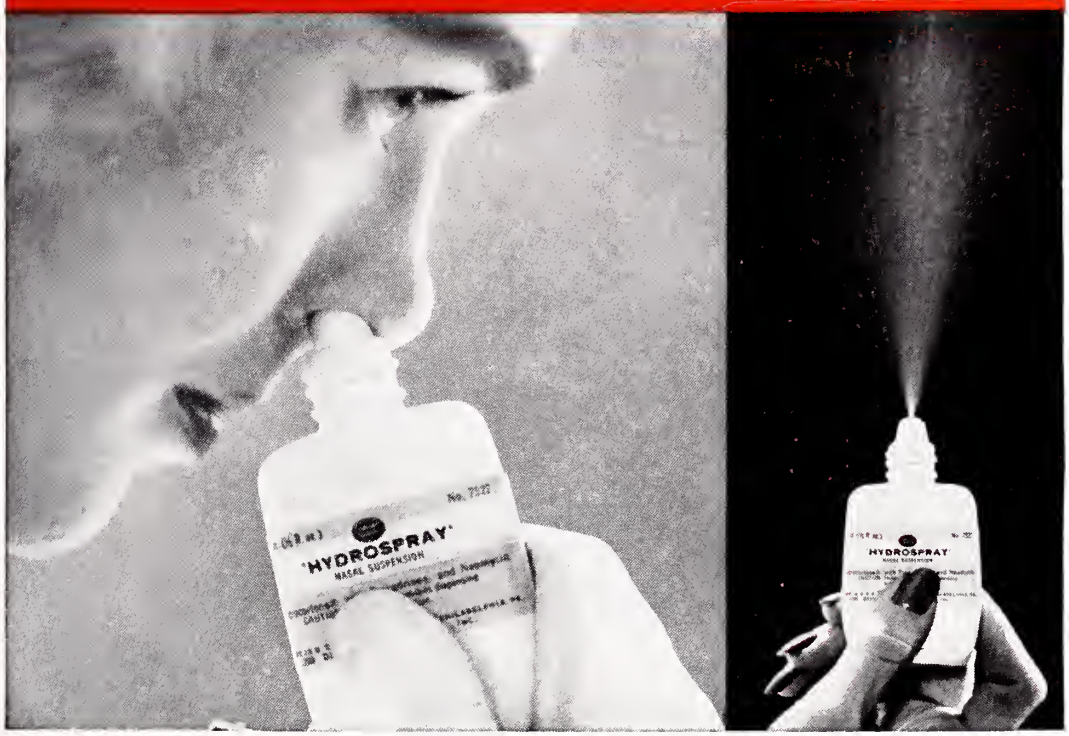
PRESIDENT

'Hydrospray' NASAL SUSPENSION

(HYDROCORTONE® WITH PROPADRINE® AND NEOMYCIN)

Anti-inflammatory—
Decongestant—Antibacterial

MAJOR ADVANTAGES: New synergistic anti-inflammatory, decongestant and antibacterial formula. High steroid content assures effective response.



Topically applied hydrocortisone[1] in therapeutic concentrations has been shown to afford a significant degree of subjective and objective improvement in a high percentage of patients suffering from various types of rhinitis. HYDROSPRAY provides HYDROCORTONE in a concentration of 0.1% plus a safe but potent decongestant, PROPADRINE, and a wide-spectrum antibiotic, Neomycin, with low sensitization potential. This combination provides a three-fold attack on the physiologic and pathologic manifestations of nasal allergies which results in a degree of relief that is often greater and achieved faster than when any one of these agents is employed alone.
INDICATIONS: Acute and chronic rhinitis, vasomotor rhinitis, perennial rhinitis and polyposis.

SUPPLIED: In squeezable plastic spray bottles containing 15 cc. HYDROSPRAY, each cc. supplying 1 mg. of HYDROCORTONE, 15 mg. of PROPADRINE Hydrochloride and 5 mg. of Neomycin Sulfate (equivalent to 8.5 mg. of neomycin base).

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.

Erythromycin in treatment of abscess

6/21/55

DISCHARGE SUMMARY

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

Communication to Abbott Laboratories.

pecific against
occic infections

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that provides *specific therapy* against staph-, strep- or pneumococci. Since these organisms cause most bacterial respiratory infections (and since they are the very organisms most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe ERYTHROCIN when the infection is coccic?

filmtab®

Erythrocin®
(Erythromycin, Abbott)
STEARATE

with little risk of
erious side effects

Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to alter intestinal flora—with an accompanying low incidence of side effects. Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN (100 and 250 mg.), bottles of 25 and 100. Abbott

filmtab®

Erythrocin®
(Erythromycin, Abbott)
STEARATE

®Filmtab—Film sealed tablets; patent applied for.



A TEXTBOOK OF MEDICINE: Edited by Russell L. Cecil, M. D., Professor of Clinical Medicine, Emeritus, Cornell University, New York, and Robert F. Loeb, M. D., Bard Professor of Medicine, Columbia University, New York. 9th Ed. 1,786 pp. Illust. W. B. Saunders Company, Philadelphia, 1955.

The new (9th) Edition of Cecil & Loeb's Textbook of Medicine reflects the continued policy of the authors to produce an up-to-date authoritative text in general medicine. Its contributors include the leading men in the various fields of internal medicine.

In addition to rewriting and bringing up to date all previously presented material, the authors have included more that 30 entirely new articles covering such subjects as the leptospiral diseases, atherosclerosis, portal hypertension, dehydration and fluid balance, senile heart disease, and cystic disease of the lungs.

In a text in which all of the articles are timely and authoritative, it is probably superfluous to make special mention of any specific one. However, the reviewer was particularly impressed with the articles on hematology by William Castle, M.D., Charles Doan, M.D., Carl Moore, M.D., and Cyrus Sturgis, M.D., on the disorders of the biliary system by Cecil Watson, M.D., on vitamins and deficiency disorders by Tom Spies, M.D., on gout by Philip Hench, M.D., on cardiac and circulatory disorders by Eugene Stead, Jr., M. D., and on bacterial diseases by Chester Keefer, M. D. The section on aviation medicine by Ashton Graybiel, M. D., of the U. S. Naval School of Aviation Medicine at Pensacola seems particularly timely in view of the increasing participation by the general public in flying activities. This section includes a discussion of the physiological stresses and other medical problems incident to flying. Of contributions by specialists outside the field of internal medicine, the articles on diseases of the pancreas by Charles Child, M. D., Professor of Surgery at Tufts, and on intestinal obstruction and intestinal neoplasms by Alton Ochsner, M. D., Professor of Surgery at Tulane, were especially good.

To summarize, the new 9th edition of Cecil and Loeb continues to emphasize the physiologic and biochemical aspects of disease and is an authoritative reference on all phases of diseases in the field of internal medicine. It is an excellent reference text, especially for students and general practitioners.

J. Richard Gott, Jr., M.D.

THE HUMAN ADRENAL CORTEX: VOLUME III OF THE CIBA FOUNDATION COLLOGUIA ON ENDOCRINOLOGY by G. E. W. Wolstenholme, OBE, MA, MB, BCh and Margaret Cameron, MA, ABLS — Little, Brown & Co.; 665 pages: $10.00.

This comprehensive collection of papers by outstanding investigators, probes deeply into the mysteries of such a small and simple subject as the adrenal cortex. The progress they report in their varied studies brings information within reach of all physicians. However, it reveals how little is really known about the hypothalamus-pituitary-adrenal axis.

The first half of the book deals mainly with histological and biochemical aspects of the pituitary-adrenal axis. There are also several topics concerned with the cortico-medullary relationships of the human adrenal gland. This should prove of interest mainly to those who are involved primarily in research or teaching in this field. Many procedures of value in measuring human adrenal cortical function are outlined and amply discussed in an informal and entertaining manner. Included in this portion of the book are many interesting illustrations and charts.

The second half of the book deals mainly with the physiological and pathological aspects of the human adrenal cortex. The papers presented in the latter portion of this symposium range from the known stimulating effects of the adreno-cortico trophic hormone on the adrenal cortex through the interesting metabolic effects of the true salt hormone, aldosterone. The therapeutic effects of hypophysectomy in cancer, Cushings disease and virilizing adrenal hyperplasia are thoroughly abscessed.

For the informal discussions as well as presentation of latest work by outstanding investigators in the field of adrenal cortex it is destined to become a standard reference.

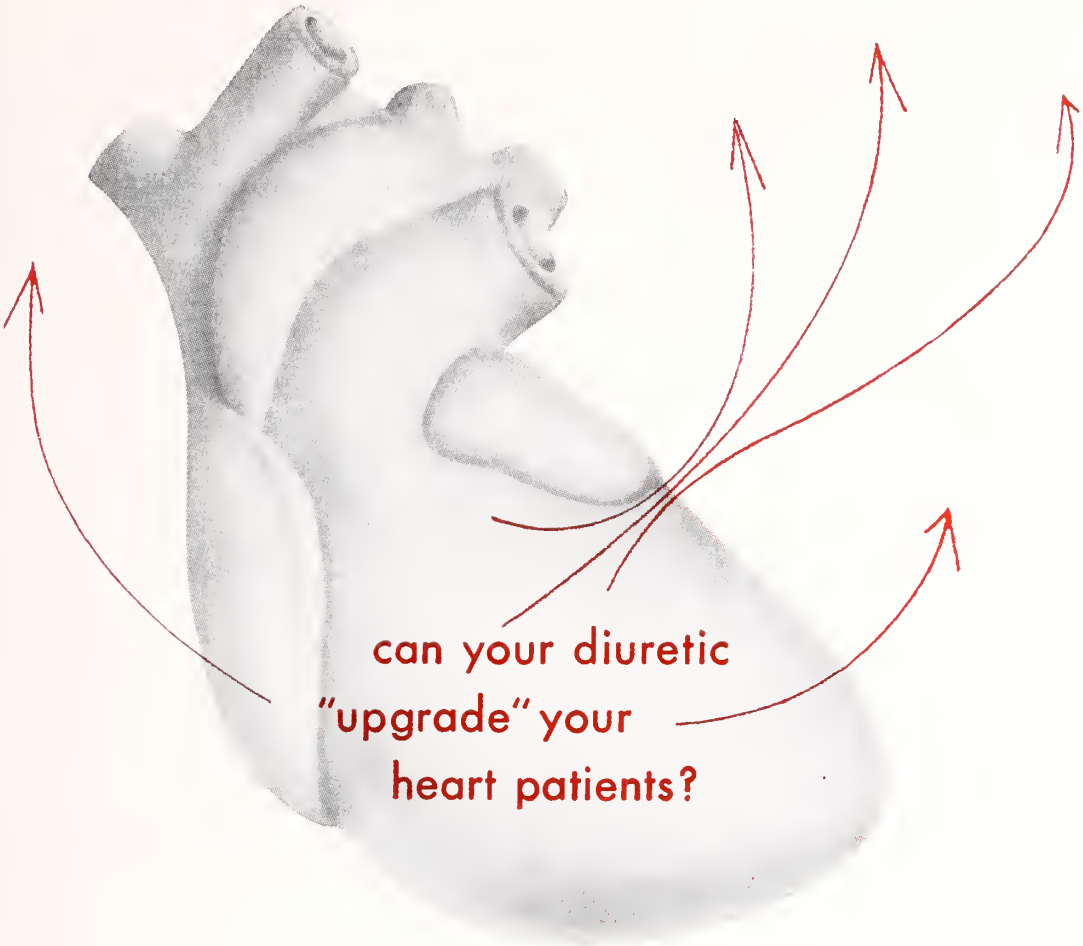
This book is an essential one for those who must make decisions regarding diagnosis and therapy concerning the effects of the adrenal cortex and hypophysis in health and disease.

Robert L. McClendon, M.D.

SHOULD THE PATIENT KNOW THE TRUTH? Edited by Samuel Standard, M. D., and Helmuth Nathan, M. D., the Springer Publishing Company, Inc., New York, 1955, 160 p.p., $3.00.

This question, SHOULD THE PATIENT KNOW THE TRUTH?, is discussed in this

(Continued on page 14)



know your diuretic

fewer restrictions of activity are the benefit of prolonged use of those diuretics effective over the entire range of cardiac failure. The organomercurials—parenteral and oral—improve the classification and prognosis of your decompensated patients. Diuretics of value only in milder grades of failure, or which must be given intermittently because of refractoriness or side effects, are incapable of "upgrading" the cardiac patient.

TABLET
NEOHYDRIN®
BRAND OF CHLORMERODRIN
(18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA IN EACH TABLET)

for "...a new picture of the patient in congestive heart failure."*
replaces injections in 80% to 90% of patients
*Leff, W., and Nussbaum, H. E.: J. M. Soc. New Jersey 50:149, 1953.

a standard for initial control of severe failure

MERCUHYDRIN® SODIUM
BRAND OF MERALLURIDE INJECTION

Leadership in diuretic research
Lakeside LABORATORIES, INC., MILWAUKEE 1, WISCONSIN

88855

IN ANC

To leave **SURE** out of INSURANCE just doesn't make sense

What can such a policy be worth? Of course, it's cheap, and you may collect, even handsomely. But isn't this pure lottery rather than Insurance?

Unless your policy is **Guaranteed Renewable - Incontestable** and **Non-Cancellable** you have bought a fair weather promise.

All "Association Group" plans may be cancelled at any time by the insurance Company.

— — — — — — — — — — —

W. R. LONG & ASSOCIATES

1534 Bardstown Road—Louisville, Ky.

Without obligation to me I would like to have more information on a sound disability insurance program. I am in good health and was

born .....
Month Day Year

Name.....

Address.....

IN THE BOOKS

(Continued from page 12)

small book by twenty-four learned persons, some of whom are physicians, nurses, a priest, a sister, a rabbi, a minister, and a lawyer, including such famous medical names as Owen Wagensteen, Leo Davidoff, Allen Guttmacher, and Paul White. This book, encompassing as it does the practical application of philosophical, moral, and religious principles, is strongly recommended for all physicians.

It is easily read. The longest essay by any of the contributors is less than fourteen pages. Its type is easy on the eyes. There are hints for everyday handling of our patients which we all should know but often get too busy to think about. The following quotations are culled in an attempt to give thumbnail sketch of the book:

"You look at the bundle of plainness and say with a pretty awe-struck voice 'That's a baby'."

"The obsessional physician—meticulously addicted to a policy of dedicated honesty finds it incumbent upon him to convey every fact and every finding."

"The truth you speak doth lack some gentleness
And time to speak it in; you rub the sore,
When you should bring the plaster."
Shakespeare: "THE TEMPEST"

"—some patients who were 'neurotic' all their lives face serious illness with firmness and bravery."

"The most important person in an illness—the patient—is forgotten by the physician as well as relatives."

"—another neurologist who developed symptoms of a malignant brain tumor made the correct diagnosis on himself and was in terror lest he lose his power of reasoning before he could convince me that he chose not to be operated upon.—"

"The doctor is never privileged to lie to a patient but he is privileged to tell the patient part of the truth."

"Later that day, I heard one of the children tell another, 'Johnny died, but don't tell the nurses'."

"Everyone has the right and duty to prepare for the solemn moment of death."

"Obviously it would be morally wrong for the physician to cause harm or damage to his patient."

Since there is obviously no one answer to this question, this book is strongly recommended to all physicians for its stimulating qualities as well as a compact reference source for modern attitudes toward the question "SHOULD THE PATIENT KNOW THE TRUTH?"

William K. Keller, M.D.

Upjohn

Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

Cortef* *tablets*

Supplied:

5 mg. tablets in bottles of 50
10 mg. tablets in bottles of 25, 100, 500
20 mg. tablets in bottles of 25, 100, 500

*REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF HYDROCORTISONE (COMPOUND F)

The Upjohn Company, Kalamazoo, Michigan





PHOTO DATA. CAMERA: 4X5 REFLEX; EXPOSURE: 1/200 SEC. AT F.8 EXISTING LIGHTING.

ACHROMYCI

Hydrocl

Tetracycline HCl



ly prescribed because of these important advantages:

- apid diffusion and penetration
- rompt control of infection
- egligible side effects
- ue broad-spectrum activity (proved effective gainst a wide variety of infections caused by iram-positive and Gram-negative bacteria, rick-tsiae, and certain viruses and protozoa)
- very gram produced in Lederle's *own* labora-ories under rigid quality control, and offered *nly* under the Lederle label
- *complete* line of dosage forms

ERLE LABORATORIES DIVISION · *American Cyanamid company* PEARL RIVER, NEW YORK

Lederle

. S. PAT. OFF.

WASHINGTON NEWS DIGEST

Washington, D. C.—The second session of the eighty-fourth Congress is under way, and in medical legislation—as in all other fields—this promises to be much livelier than last year's deliberations.

For one thing, neither the Republican administration nor the Democratic party, which is in control on Capitol Hill, got anywhere near as much as it wanted last year in medical legislation.

For another thing, and something that shouldn't be lost sight of at any time, both parties this year will be legislating with one eye cocked toward next November, when the voters make a choice between the two parties. Try as they might to pass laws for the good of all the people, neither party can afford to ignore the political realities of the situation: each will want to take credit for any legislation with popular appeal or where that is impossible, at least to see that the other party doesn't get the credit.

In front of this political mosaic, these are some of the medically-important issues that will be fought out in Senate and House:

1. Federal guarantee of mortgages on health facilities. This has been on the Congressional calendar for two years; it was pushed hard in 1954, and was given some consideration in 1955. It would mean that the federal government would underwrite mortgages for hospitals, clinics and nursing homes, under certain conditions, thereby allowing some sponsors to obtain loans they couldn't otherwise get, or to obtain them on longer terms and with lower interest.

2. Federal grants for research facilities. Under this plan—approved last session by the Senate—the U. S. would make outright grants to laboratories, medical schools and clinics for building facilities for research in specific diseases, such as cancer and heart disease.

3. Federal aid to medical education. This perennial project probably is closer to Congressional enactment now than ever before. The most popular bill is one restricting the federal role to grants for building and equipment, with a financial incentive held out to those schools willing to increase their enrollment. This bill may be tied in with some other grants bill, such as the one for research.

4. Salk vaccine. Legislation authorizing federal appropriations for the purchase of Salk poliomyelitis vaccine ($30 million for the current year) expires February 15, virtually insuring Congressional action of some sort before that date. One issue is whether the federal government should continue the grants; more controversial is the question of whether the U. S. would move in to control the allocation and distribution of the vaccine. Allocation and distribution now are handled under a voluntary program supervised by the U. S. Public Health Service.

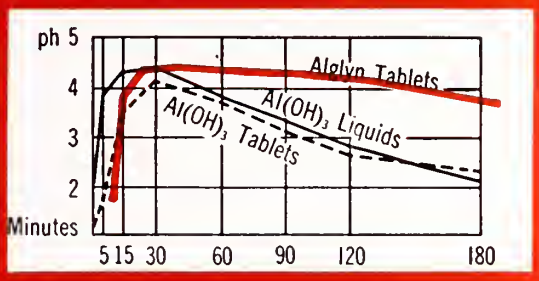
5. Increases in federal appropriations for medical research. Over the last years—since the National Institutes of Health came of age—Congress repeatedly has increased research grants over the amounts the Budget Bureau allowed Public Health Service to request. Indications are that this year the Budget Bureau may have to give way and allow important increases to be requested of Congress. Congress probably would want to add on its own special additions anyway, resulting in more money than ever before available for work on cancer, heart disease, mental illness, arthritis, blindness and the many other conditions.

6. OASI-covered persons could receive payments beginning at age 50 if determined to be disabled. Under present law retirement payments for all are available at age 65. The bill containing this provision (H.R. 7225) passed the House last session by an overwhelming margin. It is now before the Senate Finance Committee, where the next phase of the legislative contest will be fought out in 1956.

The lop-sided House vote on disability payments may be discounted in part because of the parliamentary maneuvering by sponsors of the legislation. House members had only 40 minutes to debate this bill, and no opportunity to amend it. It was a case of accepting the whole bill—which contains a number of other social security liberalizations not of medical significance—or being politically damned as opposed to social security per se.

The American Medical Association maintains that the present expanding rehabilitation programs would be undermined by cash payments for disability, that the financial and other long-range aspects of the disability payments plan have not been thoroughly studied, and that the machinery for disability payments would inevitably project the federal government deeply into the medical care picture.

Announcing Revision of N.N.R. Monograph for



ALGLYN®

dihydroxy aluminum aminoacetate, N.N.R.

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."[1]

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets.[3]

Also supplied (not N.N.R.) as **Malglyn Compound** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

1. N.N.R., 1956.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:.586, 1949.
3. Rossett, N.E. and Rice, M.L. Jr.: Gastroenterology, 26:.490, 1954.

Brayton PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

Pork in the Human Dietary

PORK MAY be looked upon as an important factor in America's general health and well-being. The average intake of pork in America is about 46 pounds of lean pork and 20 pounds of bacon and salt pork per person each year.[1] But America's demand for pork goes further than taste appeal and deeper than mere statistics. Pork makes a valuable contribution to day-in-and-day-out nutrition.

Pork rates among the foremost sources of thiamine. As a source of all other B vitamins and many essential minerals, such as iron and phosphorus, pork meat is considered an important dietary constituent.

Lean pork is virtually completely digestible. Its protein serves to promote growth and aid in the maintenance of tissue cells. Like all high quality protein, that of pork aids in the elaboration of protein hormones, enzymes, and antibodies.

Pork constitutes a valuable part of the daily diet (Table I), and also contributes importantly to the nutrition of the pregnant woman (Table II).

Pork and pork products have won America's favor by their unique combination of economy, palatability, and nutritional value.

---

1. Consumption of Food in the United States, 1909-1952, Washington, D.C., United States Department of Agriculture, Bureau of Agricultural Economics, Agricultural Handbook No. 62, September, 1953.
2. Watt, B.K., and Merrill, A.L.: Composition of Foods—Raw, Processed, Prepared, Washington, D.C., United States Department of Agriculture, Agricultural Handbook No. 8, 1950.
3. Bowes, A. deP., and Church, C.F.: Food Values of Portions Commonly Used, ed. 7, Philadelphia, Anna dePlanter Bowes, 1951.
4. Cheldelin, V.H., and Williams, R.J.: Studies on the Vitamin Content of Tissues, II, Houston, Texas, University of Texas Publication No. 4237, 1942.
5. Schweigert, B.S.; Nielsen, E.; McIntire, J.N., and Elvehjem, C.A.: Biotin Content of Meat and Meat Products, J. Nutrition *26*:65 (July) 1943.
6. Scheid, H.E., and Schweigert, B.S.: The Vitamin B_{12} Content of Meat, Annual Report, An Outline of Research During the Fiscal Year 1953-54, Chicago, American Meat Institute Foundation, Bull. 22, 1955.
7. Estimated on basis of protein content of meats. Sherman, H.C.: Food Products, ed. 4, New York, The Macmillan Company, 1948, p. 155.
8. Recommended Dietary Allowances, Washington, D.C., National Academy of Sciences—National Research Council, Publication 302, 1953.

Cooked Pork Chops, Ham, and Pork Sausage
Nutrients and Calories Provided by 3-Ounce Portions

TABLE I	Protein Gm.	Thiamine mg.	Niacin mg.	Riboflavin mg.	Iron mg.	Phosphorus mg.	Calories
Pork Chops, without bone, cooked, 3 oz.[2]	20	0.71	4.3	0.20	2.6	200	284
Ham, without bone, cooked, 3 oz.[2]	20	0.45	4.0	0.20	2.6	202	338
Pork Sausage, cooked, 3 oz.[3]	14	0.42	2.8	0.20	2.1	139	396

3.5 ounces of fresh pork loin, equivalent to approximately 3 ounces of cooked loin, contains 0.47 mg. pantothenic acid;[4] 0.10 mg. pyridoxine;[4] 0.005 mg. biotin;[5] 36 mg. inositol;[4] 0.08 mg. folic acid;[4] 0.0027 mg. vitamin B_{12};[6] 63 mg. chlorine;[7] 0.1 mg. copper;[7] 20 mg. magnesium;[7] 280 mg. potassium;[7] 70 mg. sodium;[7] and 0.01 mg. manganese.[7]

TABLE II
Nutrients and Calories of Cooked Pork Chops (3 ounces) Expressed as Percentages of Recommended Daily Dietary Allowances[8]

Percentages of Allowances for:	Protein	Thiamine	Niacin	Riboflavin	Iron	Phosphorus	Calories
Girls, 13-15 years of age; weight, 108 lb.; height, 63 inches.	25%	55%	33%	10%	17%	15%	11%
Women, 25 years of age; weight, 121 lb.; height, 62 inches.	31%	59%	36%	14%	22%	17%	12%
Pregnant Women (3rd trimester)	25%	47%	29%	10%	17%	13%	11%

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago... Members Throughout the United States



THORAZINE* *can allay the suffering caused by the pain of SEVERE BURSITIS*

The ataractic, tranquilizing action of 'Thorazine' can reduce the anguish and suffering associated with bursitis. 'Thorazine' acts not by eliminating the pain, but by altering the patient's reaction—enabling her to view her pain with a "serene detachment" . . . Howell and his associates[1] reported: "Several of [our patients] expressed the feeling that ['Thorazine'] put a curtain between them and their pain, so that whilst they were aware that the pain existed, they were not upset by it."

'Thorazine' should be administered discriminately and with the care to be observed with all serious medication. Consequently, it is important that the physician, before prescribing 'Thorazine', be fully conversant with the available literature.

Smith, Kline & French Laboratories, Philadelphia

1. Howell, T.H.; Harth, J.A.P. and Dietrich, M.: Practitioner *173*:172.
*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

RAPIDLY EFFECTIVE

BROAD-SPECTRUM ANTIBIOTIC THERAPY

. . . WELL TOLERATED . . .

BY THE INTRAMUSCULAR ROUTE

TERRAMYCIN®

Brand of oxytetracycline

INTRAMUSCULAR

"IN CHILDREN, GASTROENTERITIS, CROUP, MENINGITIS, AND INFECTIONS COMPLICATING CERTAIN SURGICAL CONDITIONS MAY BE ADEQUATELY TREATED BY ITS USE AND IT IS . . . [A] DRUG OF CHOICE WHEN ORAL MEDICATION IS NOT POSSIBLE."*

*Schaefer, F. H.: Ohio State M. J. 51:347 (April) 1955.



TERRAMYCIN INTRAMUSCULAR

Single-dose vials providing 100 mg. crystalline oxytetracycline hydrochloride, 5 per cent magnesium chloride and 2 per cent procaine hydrochloride.

Pfizer

PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

24-hour control

for the majority of diabetics



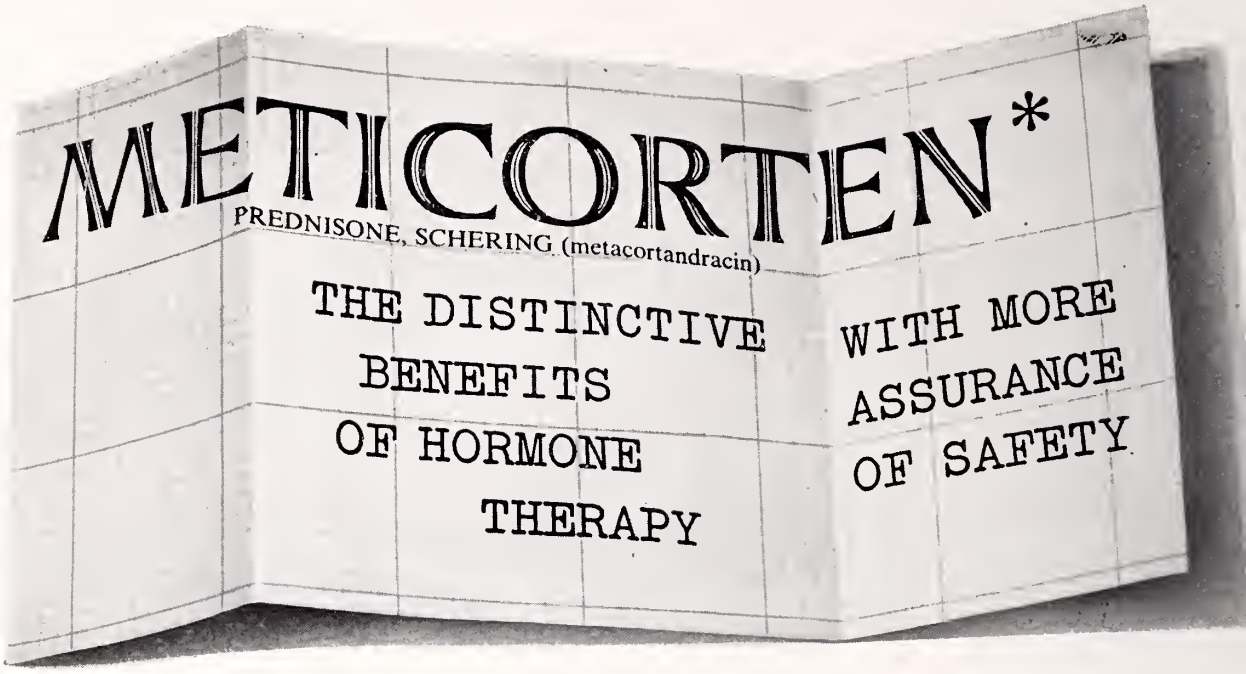
GLOBIN INSULIN

'B.W. & CO.'®

a clear solution . . . easy to measure accurately

Discovered by Reiner, Searle, and Lang
in The Wellcome Research Laboratories

BURROUGHS WELLCOME & CO. (U.S.A.) INC. • **Tuckahoe 7, New York**



For physicians who hesitate to use the older corticosteroids because of diminishing therapeutic returns and frequently predominating major undesirable side effects, METICORTEN with its high therapeutic ratio reduces the incidence of certain major undesirable side effects.

- minimizes sodium and water retention
- minimizes weight gain due to edema
- no excessive potassium depletion
- in rheumatoid arthritis, effective relief of pain, swelling, tenderness; diminishes joint stiffness
- in intractable asthma, relief of bronchospasm, dyspnea, cough; increases vital capacity
- clinical response even where cortisone or hydrocortisone ceases to be effective—"cortisone escape"
- effective in smaller dosage

BIBLIOGRAPHY

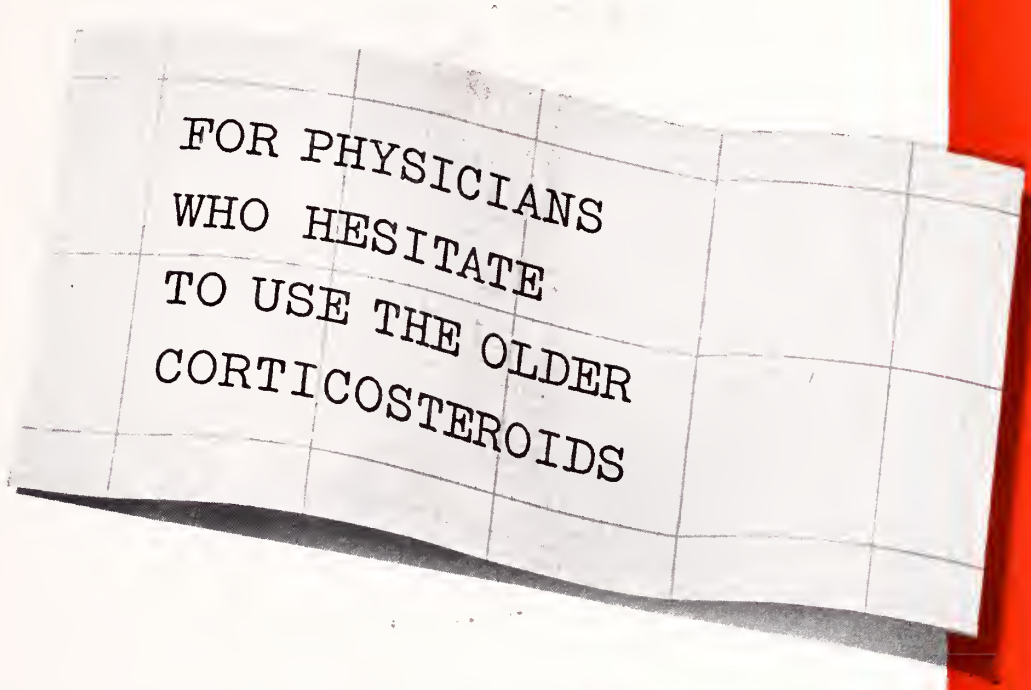
(1) Bunim, J. J.; Pechet, M. M., and Bollet, A. J.: J.A.M.A. *157*:311, 1955. (2) Gray, J. W., and Merrick, E. Z.: J. Am. Geriat. Soc. *3*:337, 1955. (3) Boland, E. W.: California Med. *82*:65, 1955. (4) Dordick, J. R., and Gluck, E. J.: J.A.M.A. *158*:166, 1955. (5) Margolis, H. M., and others: J.A.M.A. *158*:454, 1955. (6) Hollander, J. L.: Philadelphia Med. *50*:1357, 1955. (7) Barach, A. L.; Bickerman, H. A., and Beck, G. J.: Dis. Chest *27*:515, 1955. (8) Arbesman, C. E., and Ehrenreich, R. J.: J. Allergy *25*:189, 1955. (9) Skaggs, J. T.; Bernstein, J., and Cooke, R. A.: J. Allergy *26*:201, 1955. (10) Schwartz, E.: J. Allergy *26*:206, 1955. (11) Nelson, C. T.: J. Invest. Dermat. *24*:377, 1955. (12) Robinson, H. M., Jr.: J.A.M.A. *158*:473, 1955. (13) Herzog, H. L., and others: Science *121*:176, 1955. (14) Perlman, P. L., and Tolksdorf, S.: Fed. Proc. *14*:377, 1955. (15) King, J. H., and Weimer, J. R.: Experimental and clinical studies on Meticorten (prednisone) and Meticortelone (prednisolone) in ophthalmology, A.M.A. Arch. Ophth., in press. (16) Barach, A. L.; Bickerman, H. A., and Beck, G. J.: Clinical and physiological studies on the use of metacortandracin in respiratory disease. II. Pulmonary emphysema and pulmonary fibrosis, Dis. Chest, to be published. (17) Dordick, J. R., and Gluck, E. J.: Preliminary clinical trials with prednisone (Meticorten) in systemic lupus erythematosus, A.M.A. Arch. Dermat. & Syph., in press. (18) Goldman, L.; Flatt, R., and Baskett, J.: Assay technics for local anti-inflammatory activity in the skin of man with prednisone (Meticorten) and prednisolone (Meticortelone), J. Invest. Dermat., in press.

METICORTEN,* brand of prednisone.
*T.M.

in

rheumatoid arthritis,

intractable asthma, rheumatic fever, nephrosis, certain skin disorders such as acute disseminated lupus erythematosus, acute pemphigus, extensive atopic dermatitis and other allergic dermatoses, and certain eye disorders



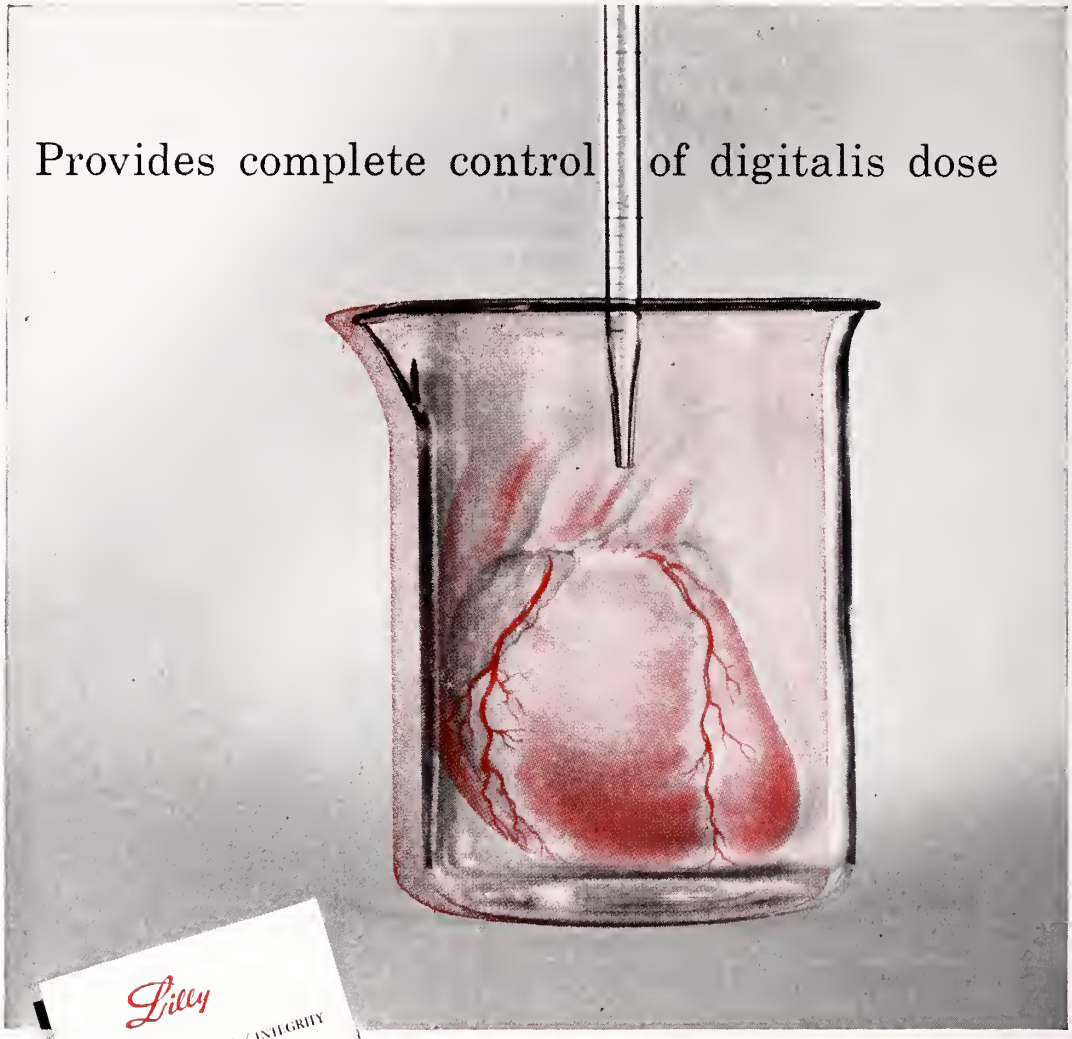
METICORTEN

PREDNISONE, SCHERING (metacortandracin)

SCHERING CORPORATION · BLOOMFIELD, NEW JERSEY

Schering

MC-J-520



'Crystodigin'

(CRYSTALLINE DIGITOXIN, LILLY)

. . . . . permits accurate dosage titration to produce the maximum therapeutic effect

Available in scored tablets of 0.05 mg. (orange), 0.1 mg. (pink), 0.15 mg. (yellow), and 0.2 mg. (white); and in 1-cc. and 10-cc. ampoules, 0.2 mg. per cc.

Since initial digitalization and maintenance dosage must be carefully individualized, 'Crystodigin' fulfills the important requirements of a preferred digitalis. 'Crystodigin' is a crystalline-pure, uniformly potent single glycoside that is completely absorbed in the gastro-intestinal tract. With 'Crystodigin,' the maximum therapeutic effect can be safely determined by dosage titration in increments as small as 0.025 mg.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

666000

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHTY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 JANUARY, 1956 NO. 1

Fire and Explosion Hazards With Flammable Anesthetic Agents and Their Control*

GEORGE J. THOMAS, M. D.**

Pittsburgh, Pennsylvania

Death by anesthetic explosion is given heavy emphasis in media of public information, not only because it is the most dramatic of all surgical fatalities, but also because it is so unusual.

Dramatic and newsworthy though death by anesthetic explosion may be, it is relatively rare and infrequent among the causes of death of patients undergoing surgery.

Tragedies from fires and explosions have occurred in operating and delivery rooms ever since flammable anesthetic agents have been used. It is true that such accidents are rare and occur only once in approximately 80,000 to 100,000 anesthesias. However, definite hazards are present in places where flammable anesthetic agents are used. Therefore, definite precautions must be taken to avoid or, at least, further minimize these catastrophes since there over 10,000,000 anesthesias administered in the United States annually.

The danger of fire and explosion is not limited to the field of medicine but is also a factor in industry where flammable agents are used in the manufacturing of many products. However, industry has taken definite steps to minimize these hazards by improvements in the physical plant and by intensive instructions to personnel on safety measures. This practice has not been the general rule in most hospitals where flammable anesthetic agents are used. The hospitals alone cannot be accused of negligence along these lines. Until recently, recommendations made to hospitals for the prevention of fires and explosions have been so variable and controversial that the requirements have been difficult to fulfill. However, today we have nearly reached agreement on the solution of many of these controversial problems.

Factors Conducive To Fires And Explosions[1]

The three essential factors required for the development of a fire or an explosion are:

1. *Combustible gases or vapors.* In ordinary anesthesia practice, the gases or vapors are ethylene, cyclopropane, diethyl ether, and divinyl ether, or a combination of these. We must not exclude the nitrous oxide-oxygen-ether sequence, because this mixture is also flammable.

2. *Oxygen supply.* Oxygen is essential to all ordinary combustion. In anesthesia, oxygen is supplied pure, diluted in air, or in chemical combination with nitrogen in nitrous oxide.

3. *Ignition source.* Flammable mixtures require an ignition source for an explosion to occur. Ignition sources may be small flames, incandescent surfaces, local combustion initiated by catalysts, and electric sparks.

Factors 1 and 2 are essential to practical anesthesia. However, the third factor, the ignition source, is not essential and should be controlled or eliminated (Table 1).

Open flames, such as those provided by alcohol lamps, Bunsen burners, matches, and smoking should be prohibited in

*Delivered on April 12, 1955 at Owensboro, Kentucky.

**Associate Professor of Surgery, and Chairman, Section on Anesthesiology, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania; Director of Departments of Anesthesiology, St. Francis General and Medical Center Hospitals, Pittsburgh, Pennsylvania.

TABLE 1

Limits of Flammability of Anesthetics***

Anesthetic Agents	Density of (Air taken as 1)	Limits of Flammability					
		In Air		In Oxygen		In Nitrous Oxide	
		Lower	Upper	Lower	Upper	Lower	Upper
Ethylene	0.97	3.05	28.6	2.90	79.9	1.90	40.2
Propylene	1.45	2.00*	11.1	2.10	52.8	1.45	28.8
Cyclopropane	1.45	2.40	10.3	2.48	60.0	1.60	30.3
Ethyl chloride	2.23	4.00	14.8	4.05	67.2	2.10	32.8
Ether-divinyl	2.42	1.70*	27.0*	1.85	85.5	1.40	24.8
Ether-diethyl	2.56	1.85*	36.5*	2.10	82.0	1.50	24.2
Nitrous oxide	1.52	Not Flammable		Not Flammable		Not Flammable	
Chloroform	4.12	Not Flammable		Not Flammable		Not Flammable	

* Tests made in 8 liter, cylindrical, closed steel bomb.
*** Jones, G. W., Kennedy, R. E., and Thomas, C. J.: Technical Paper 653, U.S. Bureau of Mines, 1943.

rooms where anesthetics are either administered or present.

The use of incandescent or high frequency cauteries or coagulators within a distance of 2 ft. from the mouth of a patient receiving flammable anesthetics should be prohibited unless a rubber sheet and wet drapes are properly applied.

On rare occasions, explosions of ether (from peroxides) have occurred due to the effect of sunlight. Ether should always be stored in original cans or dark glass bottles. Unless amber glass jars are supplied by the manufacturers, any ether remaining in the anesthesia machine should be removed and properly stored at the end of the day's work.

Electrical equipment should be inspected frequently to detect faulty operation, broken switches and plugs, frayed cords, and open sparks. Unless the equipment is explosion-proof, it should not be used where concentrations of flammable anesthetic gases may be present.

Roentgen ray and fluoroscopic equipment can cause fire or explosion when flammable anesthetic agents are being used. Roentgen ray apparatus is often brought into the operating room during the administration of an anesthetic agent. Modern shockproof equipment decreases the hazard of fire and explosion but does not eliminate it entirely.

Static Electricity

Static electricity, which is electricity at rest, is the cause of a high percentage of explosions in hospitals. It is usually produced on nonconductors but can be transferred and retained on insulated conductors.

Friction between dissimilar, nonconductive materials produces static charges. Some examples of this are the shuffling of feet across a rug on a dry day, running a comb through the hair, rubbing a glass rod with silk or synthetic fabric, and separation of woolen garments, upholstered furniture and so forth. Static charges can also accumulate by inductive processes on articles that are near electrically charged objects.

Most materials permit electricity to pass through them, but some materials are such poor conductors that they are considered insulators. Metals and carbon are good conductors, whereas acids, salt solutions, plants, and animals are relatively poor conductors. Various oils, dry wood, silk, rubber, plastic, glass, and air are considered insulators.

Development of electrostatic charges in the average operating room is impossible to prevent. There is so much activity that frequently frictional contact occurs with one or another of the many nonconductive materials that are present in the room, and charges are thus generated.

The only means of preventing the accumulation of static charges thus produced is to provide paths by which the electrostatic charges may flow away as fast as they are generated. This can be done through the use of conductive floors

and efficient conductive contact thereto. All movable conductive objects and personnel present in a room where flammable anesthetic agents are administered should have proper electrical contact with the floor.

Grounding

Grounding chains are useful for removing static electricity from operating room equipment only if the following conditions are observed:

1. The floors must be definitely conductive or have metal dividing strips closely spaced.
2. The chains should make long-line contact with the floor if the floor is conductive, or with at least two metal strips if it is not. Chains which are so short that only one or a few links are provided in contact with the floor cannot be relied upon to remove static. Long chains on tables, stools, carriages, gas machines, and so forth, will not be in the way if they are placed diagonally underneath the equipment. To insure greatest benefit, two diagonal chains should be used on each piece of equipment.
3. Chains should be cleaned occasionally to remove dirt, wax, grease, soap, oxide films, or other foreign substances which may accumulate between the links and cause high resistance. A stiff brush and a greaseless detergent should be used for this purpose.
4. Chains having open links, e.g., bronze or brass window-sash chain, are preferable to those of the ball or beaded type, which have conductive parts that are inaccessible for cleaning. They should be of material that will not rust or give off abrasive sparks when dragged over concrete or other hard surfaces.

If the floor has high resistance, the problem of grounding is solved satisfactorily by the use of one moistened and two wet towels or any other sizeable pieces of fabric. The moistened towel is folded lengthwise; one end is placed under the patient's shoulder, against the bare skin, and the other end is tucked between the mattress and the top of the operating table. One wet towel is laid above the caster from the base of the table to the floor toward the anesthetist's foot. The anesthetist's foot and the stool touch one or both of the towels. The other wet towel is stretched from the foot of the gas machine to the floor. Moistened and wet towels employed in such a manner provide excellent interconnection and grounding even though a standard test may indicate high floor resistance (Figure 1). The explanation for this recommendation is as follows:

Conduction of electricity to ground through a floor is accomplished through many paths of high resistance. When a contact to the floor is made with a chair, plate, or a chain, only a few of the available paths to ground are used. When contact is made through a large wet towel, cloth, or pool of water placed on the floor, thousands of such paths are made available and the neutralization of charges is easily accomplished.[2]

Conductive Floors

The floor is usually the most convenient common path for electrical charges to follow. Floors made of rubber, linoleum, tile, or marble are very poor electrical conductors. Neutralization of charges through such floors requires considerable time. A dangerous spark may occur before the neutralization is complete.

A terrazzo floor with conductive metal grilles may or may not be sufficiently conductive. Several other types of satisfactory conductive floors are on the market and new ones are appearing from time to time. In planning the installation of conductive floors, consideration must be given not only to conductivity but to cost, durability and appearance.

Humidity

Many anesthetists believe that an atmosphere of high humidity prevents the accumulation of static electricity and

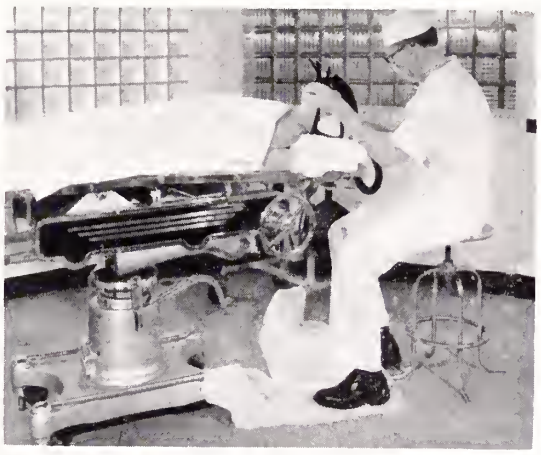


FIGURE 1 Method of using wet towels for removal of static electricity during anesthesia.

thereby eliminates explosions caused by electrostatic charges. However, several explosions have been reported with the relative humidity at 65 per cent. In April 1949, an explosion attributed to a static spark occurred when the relative humidity was 76 per cent.

Air-conditioned operating rooms are certainly desirable, but some authorities are of the opinion that artificially conditioned operating rooms are more dangerous than nonconditioned rooms, due to the removal of carbon dioxide from the air. These authorities believe that it is the carbon dioxide in the humid atmosphere which is effective in giving conductivity to insulators.

While this seems plausible, it is not altogether true, because most chargeable surfaces and insulators in operating rooms are contaminated with dust, soap films, and so on, which probably furnish more ions in solution than would be furnished by the carbon dioxide. Unless the relative humidity is high, it may not prevent the possible electrification of rubber parts, woolen blankets and synthetic fabrics. Furthermore, unless the equipment is in permanently good condition, it may fail to provide protection when it is most needed.

Electrical Equipment

Receptacles and plugs which cannot be pulled apart accidentally should be installed where needed. They should not be placed in or near the floor where heavy anesthetic gases are apt to pass over them, and they should be well out of the range of combustible gas mixtures. This precaution also applies to heaters, open motors, and switches.

In new building construction, the electric wiring should conform with the latest approved regulations of the National Fire Protection Association and the National Electrical Code.

Anesthesia Equipment

Each gas machine should be equipped with conductive rubber breathing tubes, mask, and bag. Many of the conductive rubber breathing tubes today have connectors at each end made of plastic or some other nonconductive material. All connectors should be metal or of some other conductive material, or the purpose for which they were made is defeated.

High resistance rubber casters are still present on most gas machines today. Heavy bronze or brass window-sash grounding chains should be installed on all anesthetic equipment and operating tables, provided the floors are definitely conductive or have closely spaced metal dividing strips.

It is always dangerous to move anesthetic appliances and extreme caution should be exercised, especially when they are moved across nonconductive floors. Altering the connection or changing connections during the course of anesthesia is hazardous and should only be done with extreme care. The safest procedure is to move the patient with the gas machine completely disconnected.

Operating Room Equipment

Mattresses, pads, and pillows should be covered with conductive rubber. All stretcher carriers should be equipped with the same, especially in buildings where non-conductive floors are still in use.

Operating tables, anesthetic stands, stools, and instrument tables should be equipped with a conductive material at the points where they make contact with the floor. Stools should be either left bare or else covered with conductive material.

Endoscopic instruments which operate on 6 or 8 volts do not constitute a hazard.

Wool blankets, plastic sheets, and most of the usual synthetic fabric materials should not be used in the operating room. Cotton blankets are satisfactory, but if they are kept in warming compartments, some means should be provided to keep them from losing moisture.

Personnel

Cotton uniforms are desirable from an electrical standpoint because they retain a satisfactory conductivity at fairly low humidities, and because they do not produce or acquire charge by frictional contact with other much used cotton articles, such as sheets, bandages, sterilized bundles, and so forth.

Conductive shoes should be worn by all hospital personnel. Personnel wearing ordinary rubber or synthetic soled shoes may be static carriers regardless of the type of floors in use. Soles of leather or other absorbent materials can be brought to the desirable value of 1 megohm or less in a few minutes by standing on a wet pad.

Important Things To Remember[3]

1. Avoid wool, silk, nylon, sharkskin, nonconductive rubber, plastics, and so forth, in anesthetizing locations.

2. Keep visitors away from the anesthetist and his equipment when using flammable anesthetic agents.
3. Use extreme caution in moving anesthetic appliances.
4. Exercise caution in connecting and disconnecting masks, breathing bags, or tubes because handling is capable of producing electrostatic charges.
5. Conductive soled shoes should be worn by hospital personnel. If these are unobtainable, leather soles are less objectionable than ordinary rubber or composition shoes.
6. Conductive floors should be installed in all anesthetizing locations.
7. All equipment on the floor should make proper electrical contact with the floor.
8. Paper wrappings should be removed before placing gas cylinders in service so that the cylinder label may be clearly visible.
9. Do not permit oil, grease, or flammable liquids to come in contact with oxygen cylinders, valves, regulator gauges, or fittings.
10. Do not lubricate regulators, fittings, or gauges with oil or any other combustible substance.
11. Always clear the particles of dust and dirt from the outlet of each cylinder by slightly opening the valve and closing it before applying any fitting to the cylinder.
12. Do not permit oxygen to enter the regulator suddenly. Open the valve slowly. When opening the valve, point the face of the regulator gauge away from the operator and other personnel.
13. Do not use oxygen fittings, valves, regulators, or gauges for any service except oxygen.
14. Gases should never be mixed in or added to an oxygen cylinder or any other cylinder by hospital personnel.
16. Do not attempt to use regulators that are in need of repair, or cylinders having valves that do not operate properly.
16. Do not attempt to repair defective oxygen equipment unless you are properly trained and qualified for such work.
17. Cylinder valves should be fully opened when in use.
18. Cylinder valves should be closed at all times except when gas is actually being used.
19. Employ block anesthesia or spinal analgesia or produce anesthesia with nonvolatile agents when these are suitable.
20. Use the carbon dioxide absorption technique in the administration of inhalation agents. The anesthetist should carefully observe the following routine: (a) Touch a patient and the gas machine before releasing vapors or gases. (b) Bring the mask into contact with the face after it has been connected with the apparatus. (c) Allow only a nonflammable mixture to flow until all contacts are made. A low oxygen concentration might be used for the first half minute of the induction period. (d) Use deliberation in all movements. Break and remake connections of the mask with the patient and of parts of the breathing apparatus only when each part is in your own hands.

Finally, always be on the alert against that silent, unseen hazard that is least understood and most neglected—"static or frictional electricity." A spark that can scarcely be seen or felt can prove disastrous.

Simple and Reliable Test[1]

Nonflammable anesthetics should be employed when electrocoagulating or fulgurating apparatus is used in connection with eye, ear, nose and throat surgery. However, in the event that a patient, already anesthetized with a flammable mixture, requires electrocauterization in the vicinity of the neck or face, the following procedures are recommended:

1. Discontinue administration of the anesthetic and move the equipment to a place at least 5 or 10 ft. away from the patient.
2. Allow the patient to breathe room air for not less than three minutes.
3. Insert a 10 cc. syringe halfway into the oral cavity, and take a sample of the exhaled gas from the patient as illustrated in figure 2.
4. Without moving the plunger, carry the syringe containing the sample of exhaled gas, as shown in figure 3, to a nearby room where an alcohol lamp may be safely lighted.
5. After the lamp has been lighted by an assistant, remove the plunger of the syringe and bring the mouth of the barrel into contact with the flame, as illustrated in figure 4. If any flammable gas is present in the barrel, it will be ignited and a puff of flame will be seen.



FIGURE 2 Method of drawing sample of exhaled gas and air.



FIGURE 3 Sample being carried to a safe place for open flame test.

Electrocauterization should not be attempted until a sample of the exhaled gas gives a negative test.

This simple procedure has been employed at St. Francis General Hospital for the past 15 years and we have found it convenient and reliable.



FIGURE 4 Plunger removed and mouth of syringe barrel applied to alcohol lamp flame.

Conclusion

Manufacturers, architects, and builders concerned with hospital construction, should be thoroughly familiar with the hazards common to anesthetizing areas and should supply materials and construction that conform with modern safety code requirements.

Hospital management should be grateful for the intense interest being shown at present in safety; and should regard it as a duty of the surgeons, anesthesiologists, nurses and other operating and delivery room personnel to be thoroughly instructed in all of the causes of anesthetic fires and explosions. This duty should be impressed upon each member constantly, and a method should be devised to insure complete adherence to all recommended precautions.

REFERENCES

1. Jones, G. W., Kennedy, R. E., and Thomas, G. J.: Technical Paper No. 653, U. S. Bureau of Mines.
2. Thomas, G. J.: Do You Know, American Society of Anesthesiologists NEWS LETTER, No. 4, 13-8-9, 1949.
3. Thomas, G. J.: Do You Know, American Society of Anesthesiologists NEWS LETTER No. 12, 14:14-15, 1950.
4. Thomas, G. J.: Do You Know, American Society of Anesthesiologists NEWS LETTER, No. 11, 16:14-15, 1952.

The Indicated Status of Thrombo-Endarterectomy*

JOHN B. FLOYD, Jr., M. D.

Lexington

The treatment of organic peripheral vascular disease has advanced in the past fifteen years. The therapeutic attitude prevailing today consists of various aggressive steps to improve circulation through the vessels. These means include regional sympathectomy, graft or transplants, and thrombo-endarterectomy. At the present time, the sympathectomy is established as the single most useful surgical step in the treatment of generalized peripheral arteriosclerosis obliterans.[1]

Though arteriosclerosis is a systemic disorder, it has been pointed out that manifestations may be due to localized involvement of proximal vessels. Recognition of segmental occlusion has been followed by a need for re-evaluation of indications for local excisions with grafting, or of thrombo-endarterectomy.

Aortic transplants for the successful relief of abdominal aneurysms and aortic thromboses has been reported by DeBakey and Cooley[2]. Among other steps for replacing vessels have been recent experimental efforts to reinforce fresh autogenous venografts to the aorta with sheets of polyvinyl formalinized sponge (Ivalon),[3] with good results in 19 of 22 (86%). In unreinforced vein grafts good results are reported in only 40%.

Indications

Thrombo-endarterectomy is seldom indicated in the general overall treatment of obliterative arteriosclerosis, but a few indications are being reported. Segmental obstruction due to an old embolus is thought to be the chief indication[4]. Most of the articles reviewed extended the indications to correct obstruction due to arteriosclerosis obliterans and spontaneous thromboses.

Thrombosis is responsible for most of the acute obstructive episodes in arteriosclerotic limbs[5], 10-15% of the patients seen for symptoms due to arteriosclerosis, giving a history indicative of recent thrombosis of the large limb artery. Thrombosis is induced by changes in the wall of the vessel, slowing of the blood stream, or by alterations in the character of the blood. While secondary thromboses are due to contusion, infection, or frostbite, spontaneous thrombosis will form due to atheromatous changes in the intima. These changes vary from ridges producing eddys in the stream, to localized atheromas. The thrombosis may remain localized, or it may propagate proximally and distally for some distance. Segmental localization permits occasional consideration of a recanalizing endarterectomy.

Reboul and Laubry[6] believe this procedure should be restricted to cases of arteritis of a non-acute type and those not compensated by an adequate collateral circulation. Wylie and Gardner felt that arterial stenosis sufficient to produce ischemia should be considered an intermediate step in the development of spontaneous thrombosis, and as such, should be considered an indication for intimal resection[7]. They noted that thrombo-endarterectomy should have its widest application to high level lesions above the inguinal ligament because of the more segmental nature of the lesion. An explanation for the development of the segment is that the short distance between large collateral branches limited thrombosis to the area of the static blood column. On the other hand thrombosis of the superficial femoral artery usually extends to the popliteal because the mouths of large collateral branches are so far apart. Coelho, Leeds and Freeman presented 20 incapacitated patients with localized occlusion of the terminal aorta and common iliac arteries proved by x-ray and treated by recanalization[8]. Luke selected patients for lower aortic thrombus removal if the following criteria were fulfilled[9]. First, a good aortogram demonstrating segmentalization of the obstruction with patency of the distal vessels. Second, absence of calcification in the aorta. Third, the heart should not reveal evidence of major involvement, kidney function tests should be normal, and the patient probably should be under 60 years of age. Julian and his co-workers[10] felt that the best indication for an intimectomy existed in arteriosclerotic obstruction of the iliac arteries when there is involvement of the aorta without obstruction, but sufficient to prevent a graft and safe anastomosis. DeTakats[11] points out that while iliac stenoses or occlusions can be reamed out,

*Presented at Sam Brown Journal Club, Lexington, Kentucky, May 24, 1955.

aortic bifurcation occlusions need homologous grafts.

Diagnosis of Segmental Obstruction

Since it appears that small obstructed segments of large arteries due to old embolı or to atheromas and thromboses are most amenable to thrombo-endarterectomy, a short discussion relative to making this diagnosis should follow.

The most common complaint of patients with segmental occlusions is the development of muscular symptoms of weakness and pain on exercise[7]. The muscles involved depend upon the segmental level of obstruction. For example, calf pains are noted with occlusion of the popliteal or superficial femoral artery. In addition to calf pains, thigh symptoms are noted if the block is in the external iliac or common femoral arteries, thus effecting blood flow through the Profunda Femoris. If the occlusion level is in the common iliac arteries, to the above symptoms are added gluteal weaknesses and pain in the low back and hip after exercise. In the male with bilateral occlusion, impotence nearly always follows.

Physical findings in segmental diseases are usually minimal because the patients are younger than those seen with arteriosclerosis obliterans, and because collateral circulation may have time to develop through large proximal and distal branches. Absence of peripheral pulsations distal to the segmental thrombosis is nearly always noted. Skin atrophy and edema, rubor, and tissue necrosis usually indicate the presence of multiple and extensive lesions, and contraindicate the use of thrombo-endarterectomy.

Useful laboratory aids are probably limited to aortography, for skin temperature determination and oscillograms do not answer selective localizing questions. Radiographic portrayal of intravascular defects must have a wider use in order to select suitable cases for a direct surgical approach[9, 12]. If the needle is properly placed in the aorta and sensitivity tests are negative, no untoward results should be seen[13]. In study of the femoral vessels, four distinct types of arteriograms are seen[10]. The first type of arteriogram is that seen when a normal artery is abruptly obstructed, with a number of well filled collaterals and with distal filling of the artery. The point of obstruction is nearly always located at the level of a large collateral artery. With this picture surgery is always selected no matter how long the region of obstruction. The second type of arteriogram is similar to type one, with the addition of numerous irregular filling defects in the artery above and below the obstruction. These have been operated upon successfully. A third less frequently seen type may appear in a person with clinical signs of segmental obstruction but with no filling of the distal femoral or popliteal. An occasional case has displayed at surgery a good distal channel. The fourth type is seen in patients with diffuse disease, revealing a small irregular lumen not suitable for surgery. Julian uses these classifications as indications for vein transplants to replace superficial femoral arteries.

Historical Background

Historically, Reboul[6] reviewed earlier techniques for disobliteration of arterial thromboses. In 1894 Severeana attempted to control amputation levels of gangrenous limbs by introducing a catheter through the orifice of a main obliterated artery exposed by the amputation. The thrombus was broken up and detached by this method. In 1901, Guinard used long forceps to remove the clot. Lejars first attempted disobliteration by catheterization in 1902 through one or more limited arteriotomies. Delbet in 1911 wrote that "The easiest operation that can be done to cure arterial obstruction is incision of the artery, extraction of the thrombus and closure of the vessel." But he deplored the fact that thrombosis recurred rapidly.

Reboul feels that credit for studying this technique while using arteriography and anti-coagulants must be given J. C. Dos Santos and R. Leriche (1947). Dos Santos used two longitudinal incisions across the upper and lower limits of a segmental arterial obstruction located by arteriography, dislodged and extracted the thrombus by introducing helicoid scrapers, small spatulae, malleable stylets, curettes, and forceps. Intravenous heparin was administered during the operation.

Because of difficulty in introducing the instruments more than two or three centimeters along the arteries without tearing and piercing the wall, Louis Bazy described an operation of Disobliterative Endarterectomy[14]. A thin 2-5 mm. strip on the superficial surface of the artery is cleared carefully preserving all other vessels in the adventitia. Control of the blood flow is obtained with guide sutures under important collaterals and with clamps above and below the obliterated segment. On

opening the artery 4-6 cm. a cleavage plane between the living external elastic membrane and the necrotic media and intima is found.

After sequestrectomy by blunt dissection to the upper and lower limits and with irrigation by normal saline and heparin, the wound is closed in two layers with continuous 5-0 black silk, everting first the external elastic membrane and adventia. This row is then inverted. The clamps are then removed.

Julian[10] describes an everting method of intimectomy in which the elastic outer layers are rolled back like a cuff while the cleavage plane is carefully separated. After freeing about one and one half inches, a transverse incision is made at the upper limit half around the circumference, the thrombus is delivered and the process continues. In five of their six cases this technique was limited to the common and external iliac arteries.

Heparin is used in many ways, and an effort is made to have the clotting time extended to at least 15 minutes. This is continued for one to four days. Most thromboses tend to recur very quickly when rethrombosis is noted. Long term follow-ups for patency are not yet available. Sympathectomies should probably be done in all cases[2].

In order to reinforce the arterial incision to prevent postoperative bleeding when the media is necrotic, both fascia lata[15] and a split thickness skin graft[16] have been used.

Results

Reboul and Laubry[6] presented 93 cases with complete relief and permeable vessels in 47% (43 cases), reobliteration in 40% (38 cases), and with a 10% mortality (11 cases) postoperative and remote. In appraising thrombo-endarterectomy, Wylie and Gardner[7] examined 185 patients with complaints referrable to arterial disease, performed aortograms on 132, explored 72 patients and completed the operation in 62. Of these 62, improvement was noted in 47 or 75%, and pedal pulsations in 38 or 61%. Postoperative local thrombosis was noted in four cases. Eight patients died (13%). Eleven additional cases were added with only one postoperative thrombosis.

Julian et al[10] reported six cases upon whom intimectomy was performed, with two failures (33%), though one of these could walk five times as far. Freeman and Gilfillan[17] reported on the combined use of regional heparin and thrombo-endarterectomy in 12 cases with six patent vessels, two deaths, and one mid-thigh amputation. Later 20 cases of arteriosclerotic occlusion of the terminal aorta treated by thrombo-endarterectomy were presented by Coelho, Leeds and Freeman[8] with one death, one poor result, and 18 good results. Heparin was not used in the patient with the poor result, but was used in the remainder. Luke[9] performed thrombo-endarterectomy in eight patients with lower aortic occlusion and noted a return of pulses in five patients, return of pulsation in one leg in only two cases, and one failure. Bogardus, Benetts, Huff, and Payne[18] presented six cases with iliac block, with three failures. One case with obstruction of the aorta had a good result and one case obstructed in the right common femoral artery had a good result too recently to evaluate. They performed a sympathectomy only in one case. Heinzer, Dunbar and Parsons[13] reported two cases with good results, the endarterium being removed from the terminal aorta and from the right iliac artery. Other successful cases have been reported, of the terminal aorta[16], (one case), and of the lower third of the femoral artery (3 cases) [12, 19], with a fourth case being unsuccessful. Barker and Cannon[20] pointed out the seriousness of postoperative bleeding and thrombosis, and concluded that the number of good operative results will increase as the principles of selection of patients for this operation are clarified.

	Cases	Relief	Death	Failures
Reboul and Laubry[6]	93	43	11	38
Wylie and Gardner[7]	73	58	8	5
Julian et al[10]	6	4	0	2
Freeman and Gillfillan[12]	12	6	?	4
Coelho, Leeds and Freeman[8]	20	18	1	1
Luke[9]	8	7	0	1
Boardus et al[18]	8	6	0	2
Heinzer[13]	2	2	0	0
Barker and Cannon[20]	18	6	3	9
Others	4	4	0	1
	244	154(63%)	25(10%)	63(26%)

Summary

A review of most of the recent literature in regard to thrombo-endarterectomy is presented.

A relief of symptoms in 65% of the collected series indicates that thrombo-endarterectomy may be an important future adjunct in surgery of peripheral vascular disease.

A final judgement should be based upon follow-ups over a longer period of time, to evaluate the present indicated 65% relief of symptoms.

BIBLIOGRAPHY

1 a. DeBakey, M. E., Creech, Oscar, and Woodhall, J. R., "Evaluation of Sympathectomy in Arteriosclerotic Peripheral Vascular Disease." JAMA December 1950, Vol. 144. 1227-1231.

1 b. Berry, R. E. L., Flotte, C. T., and Coller, F. A., "A Critical Evaluation of Lumbar Sympathectomy for Peripheral Arteriosclerotic Vascular Disease." SURG. January 1955, Vol. 37. 115-129.

2. DeBakey, M. E., and Cooley, D. "Surgical Consideration of Acquired Diseases of the Aorta." ANN. SURG. 1954. Vol. 139. 763-777.

3. Nortemen, J. D., Edwards, J. E., Grindlay, J. H., and Kirklin, J. W. "Reinforcement of Fresh Autogenous Venografts to Aorta." AMA. ARCH. SURG., April 1955. Vol. 70. 545-554.

4. Dos Santos, J. C., quoted by Reboul, Henri, and Laubry, P. "Endarterectomy in the Treatment of Chronic Endarteritis Obliterans of the Limbs and Abdominal Aorta." PROC. ROY. SOC. MED. XLIII. July 1950. 547-552.

5. Edwards, E. A., "Thrombosis in Arteriosclerosis of the Lower Extremity." A Monograph, P. 3, C. C. Thomas, 1950.

6. Dos Santos, J. C., quoted by Reboul, Henri, and Laubry, P. "Endarterectomy in the Treatment of Chronic Endarteritis Obliterans of the Limbs and Abdominal Aorta." PROC. ROY. SOC. MED. XLIII. July 1950. 547-552.

7. Wylie, Edwin J., and Gardener, R. "Thrombo-endarterectomy, A Clinical Appraisal." SURG. Vol. 37. March 1955. 415-426.

8. Coelho, Helio M., Leeds, F. H. and Freeman, N. E. "Arteriosclerotic Occlusion of the Terminal Aorta and Common Iliac Arteries Treated by Thrombo-endarterectomy. An Evaluation of the Procedure Based on the Results Obtained in 20 Cases." SURG. January 1955. Vol. 37. 105-114.

9. Luke, Josephus C. "Thrombo-endarterectomy in the Treatment of Lower Aortic Occlusion." AMA ARCH. SURG. 1954. Vol. 69. 205-213.

10. Julian, Ormand C., Dye, W. S., Olwin, J. H. and Jordan, P. H. "Direct Surgery of Arteriosclerosis." ANN. SURG. Vol. 136. 1952. 459-474.

11. DeTakats, Geza. "Revascularization of the Arterio-Sclerotic Extremity." An Editorial. SGO., Vol. 99. 1954. 243-244.

12. McKenzie, A. D. and Robertson, H. R. "Arterial Reconstruction (Thrombo-endarectomy) in Arteriosclerotic Disease. A Report of Two Successful Cases." SURG. 1954. Vol. 36 808-813.

13. Heinzer, B. R., Dunbar, H. S. and Parsons, H. "Thrombosis of the Abdominal Aorta and Iliac Arteries." ANN. SURG. 1954. Vol. 139. 148-157.

14. Bazy, Louis, quoted by Reboul, No. 6.

15. Wylie, E. J., Kerr, E. and Davies, O. "Experimental and Clinical Experiences with the Use of Fascia Lata Applied as a Graft About Major Arteries After Thrombo-endarterectomy and Aneurysmorrhaphy." SGO., Vol. 93, 1951. 257-272.

16. Longmire, W. P., Jr. "Thrombo-endarterectomy for Localized Occlusion of the Terminal Aorta. A Case Report: Reinforcement of the Aorta Wall With A Skin Graft." SURG. Vol. 36. 1954. 286-293.

17. Freeman, N. E. and Gilfillan, R. S. "Regional Heparinization After Thrombo-endarterectomy in the Treatment of Obliterative Arterial Disease. A Preliminary Report Based on Twelve Cases." SURG. Vol. 31, 115-131. 1952.

18. Bogardus, G. M., Beretta, F. F., Huff, R. L. and Payne, J. T. "Endarterectomy for Peripheral Arteriosclerosis." AMA. ARCH. of SURG. Vol. 68, 1954. 222-236.

19. Forty, Frank, "Obliterative Endarteritis of Femoral Artery - Disobliterative Endarterectomy." ((Reboul's Operation) PROC. ROY. SOC. MED., Vol. 44, 1951. 148-150.

20. Barker, W. F. and Cannon, J. A. "An Evaluation of Endarterectomy." AMA. ARCH. SURG., Vol. 66, 1953. 488-495.

Heart Disease In Pregnancy*

C. BRINLEY BLAND, M.D., F.A.C.S. **

Philadelphia

Not until 1920, was any extensive study inaugurated concerning heart disease in pregnancy. Before that time only meager references were found in the literature. One is appalled by the lack of understanding of the subject when one peruses the rather sparse comments to be found in the writings of the early part of the century. How could the physician attempt proper diagnosis and therapy of heart disease in pregnancy, when the physiological changes occuring in the cardiovascular system of normal pregnant women were not clearly understood at that time? Prior to 1941, when Hamilton and Thomson's extensive monograph titled, "The Heart In Pregnancy and The Childbearing Age," was published, only brief treatises concerning "Heart Disease in Pregnancy" had been written.

The first combined Cardiac-Maternity Clinic in this country was established at the Lying-In Hospital in Boston in 1921, less than thirty-five years ago.[1] In 1926, a similar clinic was organized at the Brooklyn Hospital.[2] In 1948,, the Cardiac-Obstetrics Clinic was organized at the Pennsylvania Hospital in Philadelphia.[3] The Cardiac-Maternity Clinic at the Jefferson Medical College Hospital has as its date of origin, October 22, 1953. It would certainly appear that we have been quite tardy in this endeavor and I believe we can be justly criticized for not having initiated a combined clinic such as this many years ago. We have now conducted this clinic for one and a half years and it has been running at capacity level since the opening day. We believe we have now

*Presented at meeting of Thirteenth Councilor District of the Kentucky State Medical Associaion, April 14, 1955.

**From the Department of Obstetrics and Gynecology, Jefferson Medical College, Philadelphia, Pennsylvania.

collected an appreciable number of statistics and made certain accurate observations to substantiate or refute those already found in the literature. We have established certain principles of management for the cardiac patient during pregnancy, labor, delivery and the puerperium which I will discuss a bit later in this paper.

As maternal mortality from hemorrhage and infection has decreased as a result of improved facilities for transfusion and the discovery and use of chemotherapeutics and antibiotics, cardiac disease in pregnancy has forged more to the fore as the cause of maternal deaths.[4] By 1947 it ranked third as a cause in the greater New York area, according to Gold and Wallace.[5] Heart disease is rapidly becoming the most important complication of pregnancy. In this country it is reported to be directly responsible for 25% of all maternal deaths today. In some clinics, heart disease is now the major cause of maternal death.

It is a known fact that more than one-half of all young women with chronic heart disease bear children. There are two general groups of cardiac patients who, we may assume, have normal hearts. I refer to those that have one of the types of functional heart disease and those who have systolic mitral murmurs, either of doubtful or specific origin. As you know, functional systolic murmurs commonly occur in pregnancy due to increased blood volume or stretched valvular rings. The overall incidence of heart disease in pregnancy at Jefferson is a little less than 2%, of which 93% are of rheumatic origin. The remainder are hypertensive, syphilitic, congenital and coronary types. Let us consider the miscellaneous groups.

Hypertensive Disease

This usually occurs in the older age groups. In general, patients with elevation of systolic or diastolic blood pressure do not tolerate pregnancy well. On occasions, the tremendous desire to have children, or the religious aspect will alter our judgements and we may permit individuals who do not have a marked elevation of blood pressure (160-180/90-100), who do not have significant kidney and eye ground changes, or a history of previous decompensation, to go through one pregnancy.[6] However, it is a known fact that following the pregnancy, the hypertension usually increases and the life expectancy of the individual is shortened. We are following a group of patients, now postpartum, who had no hypertension during pregnancy or labor but developed a low grade hypertension in the puerperium which has persisted for three to six months or longer. We do not know yet the significance of this, but are endeavoring to study these patients thoroughly after six months, if the hypertension still exists. It is also quite well known that toxemia is more prone to occur superimposed on a pre-existing hypertension (seven times as frequent)[7]. In regard to toxemia, a group in Winston-Salem reports the fact that toxemias are found in 35% of all patients with heart disease in pregnancy.[8] Our results at Jefferson do not substantiate this high incidence, our incidence being about 14.8%.

Syphilitic Heart Disease

Since vascular syphilis has a predilection for the aortic valve, luetic heart disease, if complicated by pregnancy, has potential aortic valvular disease as the main factor. These patients usually tolerate pregnancy well, provided that the aortic insufficiency is an early lesion. However, we can rest better knowing that cardiovascular syphilis is rarely found in women of childbearing age, as it takes twenty years for it to develop after the initial infection. Aneurysm is a definite contraindication to pregnancy and therapeutic interference should be carried out at once.

Congenital Heart Disease

This group is divided into two principal classes, namely, the cyanotic and acyanotic groups. The cyanotic group should never become pregnant and if they do, therapeutic interruption is mandatory. The acyanotic group, (provided there has been no history of previous decompensation) can generally tolerate pregnancy fairly well, and subsequent pregnancies depend upon whether the patient developed heart failure and whether there was an increase in the degree of cardiac damage. We have observed a woman at Jefferson who has a patent ductus arteriosus and has gone through four pregnancies without a mishap. Cardiac surgery could be considered for a certain number of these congenital anomalies, but more about that later. Thus, patent ductus and interventricular septal defect, usually do well in pregnancy. Pulmonary stenosis is questionable; it is now an operable lesion, but one with a fairly high risk rate. In coarctation of the aorta, 50% rupture their

aorta in labor and the danger of cerebral hemorrhage is great. Coarctation with very high blood pressure is an exception to this generalization. Cardiac surgery is becoming the treatment of choice for this anomaly. The mortality rate in coarctation in pregnancy before surgery came along was 75%.[9] Thus, women with congenital heart disease, showing no cyanosis, survive pregnancy and labor fairly well.

Coronary Disease

We believe coronary disease is a definite contraindication to pregnancy, and early therapeutic abortion is urged. A few cases have been reported in the literature of survival after myocardial infarction in pregnancy, but it is still considered a very risky complication.

Physiologic Changes

I would now like to summarize some of the important factors concerning the physiologic changes that occur in the cardiovascular system in normal pregnant women. These should be known to all of us and they are as follows:

1. Over-estimation of the heart size is a common error among examiners. Even the x-ray can be easily misinterpreted. The heart is displaced to the left and appears more horizontal than in non-pregnant women. On the electrocardiogram we note a left axis deviation and inverted T wave.
2. There is no hypertrophy or dilatation of the normal heart in pregnancy.
3. The total cardiac output in pregnancy increases approximately 50%, and this increase begins at the fourth month, reaching its maximum at about the eighth month. [10]
4. The blood volume increases, due to a 40% increase in plasma volume and a 20% increase in the blood cell mass. The minute output of blood increases as well as the velocity of blood flow. This contributes to edema along with increased capillary permeability. Clinically recognized edema occurs in 25% of normal pregnancies (usually during the last two months).
5. Due to an increase in the pulmonary vascular bed, there is an increase in normal lung markings on x-ray examination.
6. The diaphragm is elevated but its function is not altered.
7. The circumference of the chest increases five to seven cm.
8. The vital capacity increases. It decreases abruptly in the puerperium.
9. Body weight increases until the last few days, when it decreases due to loss of body fluid.
10. The mobility of the thoracic cage increases, which in turn accounts for increased vital capacity (Relaxin-Hisaw).
11. Dyspnea is normal after the third month. It is due to the large increase in pulmonary ventilation and only a small increase in vital capacity. Dyspnea occurs in 60% of normal pregnancies. Even paroxysmal nocturnal dyspnea may occur normally.
12. The pulse rate accelerates and the pulse pressure increases.
13. There is no change in respiratory rate.
14. The blood pressure remains within normal limits. It tends to decrease from the fourth to the ninth month and increases in the tenth month. It may rise considerably in labor. If you find the blood pressure elevated in a young woman without any obvious reason, do not forget that it may be due to coarctation rather than to essential hypertension or to nephritis.[11]
15. Palpitation is extremely common in pregnancy, especially in the later stages and is entirely without significance, even if palpitations are due to extra systoles or paroxysmal tachycardia, they are still without significance. Paroxysmal tachycardia is so frequent in pregnancy that some cardiologists believe pregnancy predisposes to it. It may be treated with digitalis when it occurs.
16. The placenta acts as an A-V fistula.
17. Water retention may amount to 10% of body weight.
18. During periods of high estrogen levels, sodium retention is icreased.
19. Oxygen consumption is increased in pregnancy. The largest increase is in the last trimester. This increase amounts to 15 to 20%.
20. Fifty percent of pregnancies are complicated by systolic murmurs of grade 2 or less.
21. Ventricular extrasystoles are noted in 5% of electrocardiograms.
22. The level of the diaphragm may rise as much as 4 cm. as noted in x-rays. are normal in pregnancy. Any
23. Electrocardiograms of normal hearts

changes are due to a change in the position of the heart, rather than a change in size.

24. The error in diagnosis of heart disease in pregnancy is 10% in all cases.
25. Pregnancy does not damage the heart or accelerate the course of rheumatic heart disease. Multiparas with rheumatic heart disease live as long as nulliparas.
26. Twenty percent of women with rheumatic heart disease develop failure for the first time during pregnancy.
27. At Cooke County Hospital in Chicago, the mortality rate is 0.65% for all pregnant women with rheumatic heart disease. These women are cared for in the Cardiac-Maternity Clinic. They have found that the mortality rate of those under the care of the private physician is 10%. This is a significant difference. If a clinic can obtain these results, physicians handling private patients should also obtain these results.

Unfavorable Factors in Prognosis

I have listed below some of the factors which may unfavorably affect the outlook of the pregnant cardiac patient. These are as follows:

1. History of previous failure or presence of failure at the time of initial visit, since a large majority will fail again.
2. Auricular fibrillation increases the death rate three to four times.
3. At ages over 35 the failure rate increases, at times, as high as 40%.[12]
4. The longer the duration of the disease the greater the risk, for the patient is that much nearer the end of her disease.
5. A functional classification of III or worse.
6. Evidence of great structural damage, such as a very large heart.
7. Active rheumatic fever within one year of pregnancy.
8. The presence of acute carditis.

The above factors may likewise be used as criteria for advising against pregnancy in the non-pregnant and interruption for those already pregnant. The final decision is with husband and wife. All the physician can do is give medical advice and try to do his utmost under existing circumstances.

Management

Measures for control of the patient with heart disease during pregnancy, as instituted at Jefferson, are as follows:

1. In management, we strive to control the daily work of the heart and remove any "burdens" or prevent their development.
2. A low calorie, low salt, high protein diet is advocated.
3. Avoid excess weight. We try to limit the gain to 15 pounds. Let us not forget Hamilton's important statement, "An obese cardiac is an insufficiently treated cardiac."
4. The hemoglobin should be 80% and red blood cells, 4,500,000. We prescribe a molybdenized iron compound, brewer's yeast or other vitamin supplement. Red meats and liver are frequently prescribed.
5. Tight abdominal supports are not allowed.
6. Non-essential activity should be restricted. Regular rest periods should be instituted: two hours at noon; nine hours at night. The activity restriction should parallel the therapeutic criteria set down by the New York Heart Association Classification. After the twenty-eighth to thirtieth week most of the day should be spent in bed. Admit to the hospital for the last two weeks of pregnancy for observation and controlled rest. Limit climbing of steps. Avoid shopping and reduce walking to just around the property. It is felt by most cardiologists that this rigid restriction of activity will reduce maternal mortality in heart disease by 90%.
7. Check blood pressure, pulse, urine, etc. every two weeks in early pregnancy and more frequently in the latter months.
8. Give mental and emotional reassurance. Don't inculcate fear. Fear is one of the greatest causes of dyspnea in heart disease.
9. Oral care is necessary. Remove abscessed teeth.
10. Control intercurrent infection immediately. Even mild respiratory infections are dangerous at all stages of pregnancy. The obstetrician should know of these complications and seek the advice of an internist when such infections occur, for even early pregnancy increases the heart load. Put

the patient to bed at the onset of infection and have her remain there until well. Hospitalization is strongly advocated. Treat any throat infection with penicillin to prevent recurrent rheumatic fever. The American Heart Association is now advocating penicillin prophylaxis all through pregnancy, for women with a history of rheumatic fever. Only time will tell if this is good therapy. They recommend 1.2 million units of Bicillin per month. This treatment is now being recommended by some for a patient's entire life if chorea or heart failure has occurred. In 1950, at the Brooklyn Hospital, three of five cardiac deaths occurred in women four to five months pregnant, who had acute respiratory infection.

11. Be cautions regarding the use of dehydration regimes, which depend on deprivation of sodium and diuresis in routine management of the cardiac patient, particularly during the last two weeks, when labor may begin at anytime. Electrolyte depletion is more prone to make the patient go into shock from even moderate exhaustion, blood loss or trauma.
12. Cardiac medicaments are used as indicated. Digitalis is not used frequently at Jefferson. Some authorities advise digitalization of every pregnant cardiac regardless of symptoms. We believe there is no such thing as prophylactic digitalization. Do not give it just in anticipation of labor or impending heart failure.
13 Do not use quinidine because of its oxytocic effect.
14. The patient should be encouraged to report at once any symptoms of failure such as cough, hemoptysis, etc. The patient should avoid fatigue. Hamilton believes ordinary fatigue is the most usual cause of heart failure.
15. Some of the signs of congestive heart failure are as follows:
    a. ankle edema
    b. enlargement of the liver
    c. crepitations at the base of the lungs.
    d. paroxysmal dyspnea.

    The failure is always right sided. A pregnant cardiac patient with rales in the chest is a seriously ill patient.
16. If heart failure develops it should be managed along the following lines.
    a. Strict bed rest
    b. Low salt and adequate protein diet
    c. Diuretics—NH_4 Cl and Diamox. Calcium exchange resins are no longer used at Jefferson as the patient does not tolerate them well.
    d. Digitalization.
    e. Once having failed, the patient should remain in the hospital or under strict care at home. I prefer the hospital.

Management of the Cardiac in Labor and Delivery

1. Allow labor to start spontaneously. Artificial induction of labor is contraindicated because the closer the patient is to term at the onset of labor, the lower will be her blood volume and the more normal her labor.
2. Orthopneic position should be used in labor and delivery.
3. Good sedation to prevent strain from pain and apprenension associated with uterine contraction. Demerol and scopolamine produce tachycardia and excitement. Barbiturates may be used in small doses, however it is felt that they also may cause excitement in some cases. Morphine sulphate gr. 1/6 is a good analgesic. Natural childbirth training is advocated to overcome fear and apprehension in the cardiac patient. Close doctor-patient relationship is essential.
4. Careful observation of pulse, blood pressure, respiration. Pulse over 110 and respiration over 24 indicates impending heart failure. Thus give further sedation or rapid digitalization and seriously consider termination of labor by the least shocking means available. Oxygen by mask and 50% glucose IV for transient tachycardia and heart strain is employed.
5. Shorten the second stage of labor as much as possible. It is better to subject the patient to a little more strain to bring the presenting part down for easy extraction, rather than to embark on a difficult extraction. Low forceps extraction after the head begins to crown the perineum. Make a liberal episiotomy.
6. Anesthesia:
    a. Local or pudendal block is best if the patient is not too emotional. Too much emotional strain pre-

disposes to pulmonary edema.

b. Ether and 100% oxygen in a closed system is safe. However, induction is difficult and there is the added strain of vomiting. This strain occurs also at recovery.

c. Cyclopropane is used by some institutions because of rapid and smooth induction and the quick recovery. A high percentage of oxygen can be used with it. Cyclopropane is contraindicated in arrhythmia or if digitalis has been used because it tends to aggravate arrhythmia. Don't use whole pituitrin exact or adrenalin with cyclopropane. Pitocin may be used.

d. Chloroform should not be used. It has a direct toxic effect on the myocardium.

e. Nitrous oxide is not advised because of the marked hypoxia which is necessary for adequate anesthesia.

f. Continuous spinal should be used if spinal anesthesia is employed at all. Spinal anesthesia causes pooling of blood in the lower abdomen and extremities which in turn relieves the strain on the right heart much as does a phlebotomy. Be careful of blood pressure drop.

7. Observe the patient carefully for many days following delivery. In one series of cases reported in the literature, 75% of the cases of heart failure occurred in the puerperium.

8. Third stage—use only pitocin. Ergotrate causes spasm and thrombosis of the coronary vessels in arteriosclerotics and older women.

9. If transfusion is necessary give slowly and use packed red cells if available.

10. Early ambulation has no place in the cardiac-maternity patient. Allow the cardiovascular system to be stabilized and its reserve restored. Complete bed rest should be observed from five to seven days. Limit physical activity for at least one month.

11. The strain of nursing should be avoided. We believe it demands increased circulatory response which is undesirable.

12. Vaginal delivery is preferable to Cesarean section because the mortality rate is definitely lower. This may be due at least in part to slow closure of the uterine vascular tree during normal labor. Cesarean section should be employed only for obstetrical indications.[13] Two Cesareans were performed on cardiacs at Jefferson in 1954; one for C.P.D. and the other for a fulminating pre-eclampsia.

13. Penicillin during labor and the first five days post-partum is good prophylaxis against sub-acute bacterial endocarditis.

14. Statistics show that the chief cause of fetal death is prematurity. In one series of cases, six post-mortem Cesareans were done, but no live infants were obtained. We performed one last year at Jefferson but the infant was lost.

Cardiac Surgery

Pregnant women with mitral stenosis usually tolerate pregnancy well. Thus some cardiologists rationalize, that those who have had a valvulotomy and gone to term would have done as well with proper medical management. The figures on surgical mortality in valvulotomy are contradictory. One group presents a 5% mortality in even the best selected cases and 25% for the poorest risks. This is much higher that the mortality with just good medical management. O'Neill and Glover of the Episcopal Hospital in Philadelphia have done eight mitral commissurotomies in pregnancy with good results and no mortality. Those cases done at the Episcopal Hospital were performed between the second and fifth months of pregnancy.[14] All had had decompensation in a previous pregnancy or were decompensated in the present pregnancy. According to Zatuckni of the Temple University group, if good medical care in rheumatic heart disease fails, then mitral valvulotomy will also fail.[15] They thus seem to advocate that it should never be done during pregnancy. The chest service at Jefferson has done three valvulotomies in pregnancy with good results and no mortality. We are inclined to believe that valvulotomy has a definite place during pregnancy. We have found that there are cases that continue to get very much worse as pregnancy goes on, in spite of the best medical care. In such cases valvulotomy is definitely indicated. Cardiac surgery has further narrowed the indication for therapeutic abortion and sterilization.

Summary

In summation, may I say that good care of the cardiac in pregnancy is primarily based on a complete history and thorough physical examination. The attending doctor must obtain an adequate history; he must find out if rheumatic fever occurred in childhood, syphilis in early youth, etc. A history of any episode of heart failure is extremely important. Upon examination murmurs may be detected. Murmurs are common in pregnancy. If the murmur is presystolic or diastolic it is organic. If the murmur is accentuated by exercise, or if an apical murmur is accentuated when the patient is lying on her left side, it is more likely to be organic. Loud murmurs are often organic while soft systolic ones are of little significance. Enlargement of the left auricle, as seen in fluoroscopy, may be the first clue to a diagnosis of rheumatic mitral endocarditis. We are aware of the fact that mitral stenosis and insufficiency are the most common lesions in rheumatic heart disease. A double lesion (aortic and mitral) is more serious.

In conclusion, may I say that it is always well to keep in mind that every cardiac patient is an individual problem and when pregnancy occurs the problem is even more personal. The similarity between normal heart changes in pregnancy and real organic heart disease must be stressed. The management for one individual with a given lesion may differ entirely from that of another similar individual. In general, if one must err, it is far better to err on the safe side. It must always be remembered that there is no other problem in medicine in which the patient's wishes and desires must be so ardently heeded and in which sound clinical judgement is so often willfully ignored. We talk at great length concerning frequent consultation with a heart specialist all through pregnancy, but let us not forget that the good general practitioner or obstetrician is able to do most of the job. After all, the practitioner or obstetrician is fully capable of observing excessive weight gain, beginning of ankle edema, etc., and is well able to treat these symptoms as they arise. It is only in unusual circumstances that the cardiologist need be consulted. Due to our tremendous strides in pre-natal care in the last tweny-five years, toxemia, infections, etc. have been greatly reduced by the obstetrician and practitioner and this can also be accomplished in heart disease by careful observation and care by the same doctors. Dr. Fred Irving, emeritus professor of obstetrics at Harvard, has stated, "Medical treatment is of greater importance in the cardiac pregnancy than the obstetrical conduct of the case, but both are essential to success." Let us remember that the good obstetrician and practitioner is well equipped to handle the medical regime with well chosen and well timed cardiac consultation.

BIBLIOGRAPHY

1, 13. Hamilton, B. E. and Thomson, K. J.—The Heart in Pregnancy and Childbearing Age—Little, Brown & Co. Boston 1941

2, 5. Wallace, J. F.—Management of the Pregnant Cardiac Patient N. Y. State Journal of Medicine, Nov. 1, 1950.

3. Ullery, J. C.—Management of Pregnancy complicated by Heart Disease. American Journal of Obstetrics and Gynecology. Vol. 67, April 1, 1954.

4. Pregnancy and Heart Disease.—Heart Bulletin Nov.-Dec. 1952.

6. Semisch, C. W.—Management of Pregnant Cardiac Patient. Med. Clinics of North America. November 1945.

7, 12. Sampson, J. J.—Heart Disease as a complication of Pregnancy California Medicine: May, 1949.

8. Burt, R. L. et al—Acute Toxemia of Pregnancy associated with Organic Heart Disease—American Journal of Obstetrics & Gyn. Vol. 68, August, 1954.

9. Fabor, W. H.—Surgical approach to coarctation of aorta—Journal of A. A. M. June 21, 1952.

10. Jones, A. M.—Heart Disease in Pregnancy, Grune & Stratton, New York, 1951.

11. Campbell, M.—Heart Disease in Pregnancy—The General Practitioner, January 5, 1948.

14. O'Neill, J. and Glover, R.—Personal Communication.

15. Zatuchni, J.—Personal Communication.

Manuscript Memos

Manuscripts should be submitted in duplicate to the Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Mr. J. G. Denhardt, Times-Journal Publishing Company, Bowling Green, Kentucky.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.

Use Of Trypsin In Inflammation

BERT SELIGMAN, M. D.

Toledo, Ohio

Trypsin is a proteolytic enzyme secreted by the pancreas. In its original form, it is almost completely inactive and is called trypsinogen. In the presence of enterokinase, one of the substances found in the succus entericus, the fluid elaborated by the glands in the mucosa of the small intestine, trypsinogen is converted to trypsin. The activity of trypsin has heretofore been thought to lie exclusively in the intestinal tract where it is concerned with protein digestion. Now, following the work of Innerfield, Angrist and Schwarz (1), and Laufman and Roach (2), an anti-inflammatory effect has been proved to follow the intramuscular administration of trypsin.

Inflammation is the local response of living tissue to an irritant, which may be traumatic, chemical or bacterial. The inflammatory process is characterized by the production of an inflammatory exudate, which possesses but one function, namely to engulf and thereby isolate the irritant, achieving this thru the medium of the polymorphonuclear leucocyte. The lymphocyte, the large mononuclear cell, the eosinophil and the red blood corpuscles, though present in the fnflammatory exudate, are not of immediate concern since their function is activated later. As the polymorphonuclear leucocyte undergoes degeneration, it disintegrates with the release of proteolytic ferments. Thrombin, as well as antibacterial substances, are also released. With disintegration and release of various products, changes in surface tension occur, which in turn affect phagocytosis. As the body responds to inflammation its defense mechanism is brought into action, the degree of response being directly proportional to the stimulating agent. In work done previously as well as in this report trypsin has been observed to initiate or to enhance this anti-inflammatory effect (3).

Material and Method

This report concerns 100 patients of which 42 were males and 58 females. According to age groups 7 were between 20-29 years of age, 15 in the 30-39 group, 29 in the 40-49 group, 26 in the 50-59 group, 14 in the 60-69 group, 7 in the 70-79 group, and 2 in the 80-89 group. There were 15 patients with superficial thrombophlebitis of the great and/or small saphenous systems. Here the process was characterized by a palpable thrombus of varying length, redness, localized edema and pain, with surrounding sharply delimited cellulitis. Deep venous thrombosis, most commonly of the ilio-femoral veins, the phlegmasia alba dolens associated with pregnancy, was present in 19 patients. There was pain, fever and swelling, with pain on plantar flexion, inguinal and/or calf tenderness, and pain on pressure over the medial aspect of the tibia. The patients with chronic venous insufficiency whether due to an old postphlebitic syndrome or that engendered by varicose veins of long standing, and severe in degree, were grouped together and totaled 42. The signs and symptoms of venous insufficiency included dependent edema, foot, calf or ankle pain, induration, varicosities, eczema or dermatitis, with or without spread absorption to other parts of the body, pigmentation and ulceration. All had one or more acute exacerbations with visible upward extension of the process. Arteriosclerosis obliterans with absent pedal pulses, intermittent claudication, numbness, cold feet, burning plantar paresthesias, excessive sweating of the feet, rest pain, trophic skin changes, pallor on elevation with rubor on dependency, and delayed venous filling and flushing, with cellulitis and necrosis was present in 5 patients. Post operative cellulitis occurred in 10 patients with chronic venous insufficiency. The operative procedures in these patients involved ligation and stripping of the great and small saphenous systems, as indicated, interruption of incompetent perforators subfascially, with extensive dissection posterior to the medial malleolus down to the deep fascia, paralleling the posterior tibial vein, and extending from just below the medial malleolus to the junction of the lower and middle thirds of the leg. Operating in an area with severe fibrosis, where repeated bouts of cellulitis and lymphangitis had occurred, with recurring ulceration and retrograde venous flow, post operative cellulitis is not an unexpected complication. Cellulitis per se was present in 3, traumatic arthritis in 1, lymphedema in 3, saphenous neuritis in 1 and inguinal adenitis in 1.

Parenzyme, a suspension of crystalline trypsin in sesame oil, 5 mgs. to the c.c., was given intramuscularly to 100 patients 989 times. The minimum injection given was 1, with the maximum totaling 40, for an average of 9.89 injections per patient.

Thrombophlebitis

The results of treatment with Parenzyme are as follows: In the superficial thrombophlebitis group 14 patients had an excellent result, 1 was classified as good, with complete subsidence of all signs and symptoms. One point deserves emphasis and that concerns the thrombus which was palpable in the superficial vein at the height of the disease and was still palpable at the conclusion of Parenzyme therapy. The pain, redness and swelling were gone, and the temperature and sedimentation rate were normal. The decrease in the size of the thrombus, as treatment progressed, followed the natural course of the disease as observed in a similar group of non-trypsin treated patients. The rapidity with which the acute process abated was in marked contrast to the non-trypsin treated group (3).

Of the 19 patients with deep venous thrombosis, 13 achieved an excellent result and six were good. Once the diagnosis was established and treatment instituted there was reduction in the edema, a return to normal of the temperature and a marked lessening of the pain in the extremity. Ambulation and compression of the leg with a 4″ Ace rubber reinforced bandage was effected early. Three patients in this group developed a single sublethal pulmonary embolus. The first occurred in a 40-year old male 8 days after trypsin therapy was begun. He had had recurrent attacks of unilateral and bilateral iliofemoral thrombophlebitis for several years and had been under treatment elsewhere. Under continuing treatment he made an excellent recovery. The second pulmonary embolus occurred in a 34 year old pregnant female, para iii, gravid iv, who had had a right iliofemoral thrombophlebitis with a previous pregnancy, and who was now referred for a phlebitic process involving the left leg. After 3 days of trypsin therapy she developed thoracic pain, hemoptysis and low grade fever. Trypsin therapy was maintained and recovery was termed excellent. A 70 year old male was the third case. He presented himself three weeks after the onset of his left iliofemoral thrombophlebitis and was started on trypsin. The next day he complained of "pleurisy," had a mild cough and hemoptysis. X-rays in this case as in the two previously mentioned cases were interpreted as indicating the presence of a pulmonary infarct. Treatment with intramuscular trypsin was continued and recovery was excellent. Under trypsin therapy no patient had a major venous ligation.

Chronic Venous Insufficiency

Of the 42 patients with chronic venous insufficiency there were 22 excellent, 10 good, four fair and six poor results. Subsidence of pain, amelioration of edema, softening of the induration, perceptible lightening of the pigmentation, remission of the dermatitis of the leg as well as the absorption spread to other parts of the body, and complete or partial healing of the ulcer or ulcers, when present, constituted the criteria for inclusion in the excellent group. Lesser results were so classified. Twenty-two patients have subsequently had complete ligation and stripping of their varicosities. A word about the six poor results in this group. The first was in a 56 year old male who had a left iliofemoral thrombophlebitis 12 years before, then was subjected to a high saphenous ligation and had then developed a medial malleolar ulcer. When first seen his ulcer had been present for almost 10 years. The ulcer was healed with conservative treatment, and a superficial femoral vein interruption, with stripping of the great and small saphenous systems was carried out. After one year the ulcer recurred, and a lumbar sympathectomy was performed and a split thickness graft applied. This broke down in about six months, and intensive trypsin therapy was carried out without success. The ulcer still remains. The second was a 61 year old female with an ulcer of the right medial malleolus of seven years duration. She had a high saphenous ligation, wore Unna's boots off and on, and had many injections of sclerosing solution in the veins surrounding the ulcer, all without success. She was tried on trypsin and at first the ulcer did decrease in size only to break down again. A retrograde ligation and stripping of the great and small saphenous systems was carried out, and the ulcer was completely excised down to the deep fascia. By undermining the edges of the incision were brought together, grafting was not necessary and healing took place by first intention. Interestingly the base of the excised ulcer contained calcareous material which probably acted as a foreign body and prevented healing. The third was a 59 year old

female with stasis dermatitis of both legs, present for four years. With conservative treatment a remissive phase was induced, a ligation and stripping was performed and she was well for about two years. The dermatitis recurred and despite all forms of therapy plus trypsin, the process is still present. The fourth was a 54 year old female with a bilateral post phlebitis syndrome present for eight years. The ulcers were healed, superficial femoral vein interruption and stripping were performed with a satisfactory result for one year. The ulcer recurred on the right medial malleolus, and despite trypsin in what was thought to be adequate amounts the ulcer persists. The fifth was a 22 year old male with a six year history of chronic venous insufficiency secondary to severe long standing varicose veins who had bilateral medial malleolar ulcers when first seen. Thirteen surgical procedures had been carried out on the superficial and deep veins of both legs without success. The feet were cold, blue and wet with plantar maceration. Due to this excessive sweating of his feet it was not an uncommon thing for him to rot out his shoes. Lumbar novacain blocks produced warm, dry and pink feet, so that as a consequence of this fact a bilateral high lumbar sympathectomy was performed. Mild improvement was noted in the size of the ulcers, but the overall picture of chronic venous insufficiency left much to be desired. Trypsin was given without any change being effected. The sixth in this series was a 33 year old female with a right post phlebitic syndrome present for 11 years. Treatment over the years included a high saphenous ligation, later a superficial femoral vein ligation, then a stripping interspersed between intermittent wearing of Unna's boots, series of penicillin injections, x-ray treatments to the ulcer area, applications of dried red cells and injections of materials designed to desensitize her. Trypsin was administered 31 times without a salutary outcome.

Of the 10 patients with post operative cellulitis four were excellent, five were good and one was fair. All had a pre-operative diagnosis of chronic venous insufficiency, but for statistical purposes in evaluating trypsin, were not included in the previous group where the trypsin was given as part of the pre-operative preparation. Following the extensive surgery on the leg, previously outlined, in this group of 10 patients the incisions became edematous with reddened edges and adjacent induration which was painful on palpation. With the institution of trypsin therapy the edema, redness, induration and pain subsided with greater rapidity, and healing took place in a more normal fashion than in previously treated patients with a similar disability who did not receive trypsin.

Other Conditions

The five patients with arteriosclerosis obliterans had two excellent, one fair and two poor results. Cellulitis subsided, necrotic tissue sloughed with good epithelialization, and no parts were lost by amputation in those classified as excellent. The patient listed as fair was an 82 year old female with an ulcer above the lateral malleolus. The necrotic ulcer was replaced by clean, healthy granulation tissue but complete healing did not take place. The first poor result occurred in a 74 year old diabetic male with gangrene of the first and second toes of the right foot present for six months. He finally had a lower third thigh amputation. The second poor result was in a 62 year old female whose left leg had been amputated a year before and now presented gangrene of the right heel. She had a mid leg amputation.

Of the three patients with cellulitis per se, one involving the breast was poor, the other two, one of the buttocks and one the left ear were excellent. This last patient had consulted her physician for a small lump in the lobule of the ear. A diagnosis of sebaceous cyst was made and phenol was injected into it to destroy the secreting surface. Within an hour there was pain, edema and a violaceous discoloration which rapidly progressed so that in 24 hours the entire ear was at least two times its normal size, was now purplish black in color and exquisitely painful. Following the first intramuscular injection of trypsin there was a dramatic reduction in the edema and pain and the color approached that of the normal ear. After the fourth injection treatment was no longer necessary and the result was considered excellent.

In the three lymphedema patients, two of the praecox type, and one occurring post common femoral vein interruption, two were good, one was fair. The traumatic arthritis patient had a poor result, the saphenous neuritis which occurred in a 65 year old man, who represented an old burned out Buerger's, was fair, and the left inguinal adenitis was excellent.

Unfavorable Responses

There were 13 patients who manifested an unfavorable response to trypsin. Three

were the previously mentioned cases of pulmonary embolism, six developed localized pain, redness, induration, hives and pruritus of the involved buttock and the remaining four follow. Within minutes of receiving an intramuscular injection of trypsin a patient went into vasomotor collapse, with unconsciousness, dilated pupils, unresponsiveness to stimuli, very cold, clammy and with a death like pallor. He recovered spontaneously without any medication. Whether this was due to the trypsin, or a vasomotor response to pain produced by the needle, or the trypsin, or both is a matter for conjecture. Another patient one hour after receiving trypsin developed a generalized urticarial reaction characterized by hives, angioneurotic edema with joint pains, stiffness, limitation of motion, itching, and nausea and vomiting. This remained severe for 24 hours then rapidly subsided. Treatment consisted of oral anti-histaminics. The next reaction in a patient occurred about four hours after injection with massive edema, hives, pruritus and severe pain of the buttock. This responded to anti-histaminics. The last reaction occurred in a post phlebitic male with the usual signs and symptoms of the disease. The dermatitis was mild and involved the malleolar areas. Following the first trypsin injection the extremity became edematous, and the dermatitis increased in extent and severity. After the second injection the process worsened markedly necessitating cessation of further trypsin injections.

Discussion

The rapid subsidence of pain, redness and swelling with the return to normal of the temperature and sedimentation rate in the superficial thrombophlebitis patients treated with intramuscular trypsin was very gratifying, fully substantiating its role as an anti-inflammatory agent. Of the four patients in this group who were subsequently operated upon (complete ligation and stripping), thrombi were demonstrated to be present in all. The 19 patients with deep venous thrombosis manifested a similar response to trypsin with a steady lessening of pain, fever, redness and edema, and a return to normal of the sedimentation rate. Since no operations were performed upon any patients in this group, the fate of the thrombi cannot be elaborated upon. This group should be the most interesting from a clinical standpoint since careful follow up studies conducted on a long range basis will indicate what effect, if any, trypsin has on preventing completely or modifying in extent of severity the sequelae commonly associated with the post phlebitic patient. The patients with chronic venous insufficiency, by their response to trypsin not only indicated its anti-inflammatory effect, but also demonstrated that it produced a decrease in tissue fluid viscosity by softening of induration, decrease in edema, lightening of pigmentation, and a more normal and healthy looking skin. Those patients with post operative cellulitis had a shorter convalescence with less disability when treated with trypsin than in the group similarly operated upon but not given trypsin. Patients with arteriosclerosis obliterans who responded to trypsin did not have a reversal of necrosis, but the accompanying cellulitis and edema was quickly resolved, and sloughing of the devitalized tissue took place with subsequent epithelialization.

Summary

Intramuscular trypsin as a therapeutic agent was used in 100 patients. Of 15 patients with superficial thrombophlebitis, 14 had an excellent result, one was good. In the 19 with deep venous thrombosis 13 were excellent and 6 were good. There were 42 with chronic venous insufficiency with 22 excellent, 10 good, four fair and six poor. The 10 with post operative cellulitis had four excellent, five good and one fair. Two were excellent, one was fair and two were poor in the arteriosclerotics. Cellulitis per se produced two that were excellent and one that was poor. Of the two lymphedema praecox patients one was good, one was fair, with the lymphedema post common femoral vein interruption good. The patient with traumatic arthritis was poor, the one with saphenous neuritis fair, and the one with inguinal adenitis excellent. The anti-inflammatory effect of trypsin was evidenced by rapid and sustained subsidence of pain, fever, edema and redness with return to normal of the sedimentation rate. It is suggested that trypsin exerts some influence on reduction of tissue fluid viscosity as indicated by the softening of the indurated leg, reduction in edema, lightening of pigmentation and a healthier appearance of the skin.

REFERENCES

1. Innerfield, I., Angrist, A. A., and Schwarz, A. W.: Parenteral Administration of Trypsin; Clinical Effects on 538 Patients. J.A.M.A., 152:597, June 13, 1953.
2. Laufman, H., and Roach, H. D.: Intravenous Trypsin in The Treatment of Thrombotic Phenomenon., A.M.A. Arch. Surg., 66:552, April, 1953.
3. Seligman, B.: Clinical Experience with Trypsin. To be published—Ohio State Medical Journal.

Fluid and Electrolyte Balance in Renal Disease

STANLEY G. DOLL, M.D.*
Louisville

(Continued from Dec. Journal)

Correlation Between the Pathologic Physiology and Clinical Picture in Renal Disease

With the foregoing as a background, a correlation between the pathologic physiology and clinical picture will be attempted in part. The subjective and objective findings of the patient with renal disease are dependent on the distortion of the chemical structure of body water and its constituents. Mechanisms of this distortion have already been discussed. Singular function is rarely lost. Most often dehydration is the main disorder. This results in weakness, anorexia, apathy, thirst, and headache which are the prominent symptoms. There is inelasticity of the skin, drying of the mucosal surfaces and weight loss. Personality changes may occur when water and potassium come out of the cells of the brain.

A bleeding tendency may occur, with loss of blood from the gastrointestinal tract. Vomiting and diarrhea may occur. The hydrogen ion excretion in the distal tubule may be poor and favor production of acidosis. The ammonia producing mechanism is impaired and no substitution is then made for the sodium which is attached to the carbonates, sulfates, or phosphates; sodium goes into the urine and this reduces the amount of available base. If sufficient quantities of sodium and fluid are lost, the plasma volume is reduced and a drop in the blood pressure occurs. This renal depletion of extra-cellular sodium is probably the main mechanism of renal acidosis. Potassium loss may cause muscle weakness, decreased tendon reflexes and flaccid paralysis. Cardiac arrest may occur either from hyper or hypopotassemia. Hypermagnesia depresses the central nervous system causing some of the lethargy, stupor and coma often seen late in the course of renal disease. Calcium is also lost because of the failure to conserve base. Convulsions may occur or latent tetany may be brought out by the Chvostek and Trousseau signs. Cramping of the muscles is frequent.

Too often it is assumed that if the patient has a good urinary output the renal status is in a state of compensation. If the tubule is damaged an increased amount of urine is excreted provided there is adequate filtration but this urine may contain huge quantities of electrolytes that should have been reabsorbed. Damaged tubular cells can thus mask reduced filtration rate by poorly reabsorbing the filtrate. On the other hand damaged tubules may do a satisfactory job if the flow is slow enough. If the filtrate is small, good tubules may absorb the entire filtrate causing anuria. In such case an attempt to raise the filtration rate by whatever means indicated would in some cases restore normal renal function.

Plasma urea may not be significantly elevated in renal insufficiency and should not be considered a reliable index of renal disease. A low protein intake may cause a lower plasma urea than expected whereas tissue catabolism may elevate the plasma urea. Absorption of blood from the lumen of the bowel causes abnormally high levels without significant renal disease being present. An increased urea or NPN usually occurs as a result of decreased filtration. The urea clearance can be decreased either by diffusion of urea back through damaged tubules or by a decrease in the glomerular filtration. The urine concentration and dilution test is the best indicator of the power of the tubule to reject or reabsorb water but if the flow is slow, damaged tubules may still concentrate if not too severely damaged.

The total serum protein may be low when glomerular damage is present but as the disease progresses the shrinkage of the filter bed does not permit excessive loss and the value may once again become normal. Hypoproteinemia is usually not marked unless the glomerular filtrate fraction is normal or above. The presence of proteinuria indicates a pathologic change in the glomerulus. Hematuria may mean blood has passed through the glomerulus or it may have come from minor bleeding from the tubules. The normocytic normochromic anemia which is often present and occasionally severe, is not considered a result of blood loss through the nephron. Hematuria may result from many causes distal to the nephron. If there is acidosis or dehydration, cast formation is favored. Protein is precipitated as casts in the tubules. In the nephrotic phase (as may occur in chronic glomeru-

lonephritis) massive edema occurs because of marked albuminuria. In most cases deficient intake due to anorexia or loss due to vomiting aggravates the hypoproteinemia. With the clearing of the nephrotic phase the emphasis changes to electrolyte and fluid wasting.

Congestive heart failure may be precipitated by sodium and water retention with increase in plasma volume or may be initiated by over zealous administration of saline. On the other hand, with excessive losses of water and sodium chloride the plasma volume may drop, causing collapse.

Practical Considerations in Therapy of Fluid and Electrolyte Disturbances

One cannot outline a simple routine of management for electrolyte disturbances, for treatment is based on knowledge of the manifold disturbances of fluid and electrolyte that demand different procedures. If acidosis, alkalosis, dehydration, and edema involved only the extra-cellular fluids, treatment would be comparatively simple, using the appropriate amounts of water, sodium bicarbonate, sodium chloride, and some of the other electrolytes. It is now established that cellular as well as extracellular electrolytes are involved in many, if not most, disturbances in body water and electrolyte. Small amounts of sodium are normally present in cells and under abnormal conditions, as much as half the potassium of muscle cells may be replaced by approximately equivalent amounts of sodium. [31, 32]

The first procedure in fluid appraisal is the taking of a careful history of what has happened up to the time the patient has been seen. Fluid intake and output is estimated. This is followed by a clinical estimation of the volume of the extracellular compartment. Some idea of this may be gained by determining the degree of dryness or moisture of the mucous membranes, the presence or absence of edema, the texture of the skin, the condition of the subcutaneous tissue, the presence or absence of moisture in the lungs, and venous pressure. Hematocrit and plasma protein determination help to indicate the degree of hydration. Body weight and its fluctuations help to gauge the gain or loss of fluid.

In advanced chronic nephritis Marriott[33] gives the patient a two liter bottle and explains that, to avoid danger, it must be filled with urine every 24 hours. However, a maximum specific gravity of 1.010 requires for safety that about three liters of water be taken daily which will allow about 500 ml. to cover insensible losses.

In irreversible renal disease, disorders of fluid and electrolyte may be correctible for varying periods of time with prolongation of life. This group presents a challenge for the physician to maintain them within their narrow range of safety. In some cases temporary measures will tide a patient over a critical period until the kidneys resume homeostasis. It is to be emphasized that cardiac disease may seriously disrupt the closely related renal functions by interfering with renal blood flow. All factors known to limit abnormally the blood flow to the kidney should be corrected if possible. Repair solutions should be given before renal blood flow decline has added to the irreversible damage of the diseased kidney.

Some patients in uremia may occasionally ingest too much salt; more often they take too little. As a rule their intake of water is sufficient to offset its loss, whereas their salt ingestion is deficient; as a result they develop hypotonicity more often than hypertonicity. Increased concentration of the plasma electrolytes as a whole is uncommon in chronic nephritis and is usually a result of ill-advised and over-enthusiastic therapeutic measures, or in some cases, dietary indiscretion[23].

If relatively more water than electrolyte is lost, the plasma becomes hypertonic. The cells then lose water to the area of greater concentration. The treatment for this state (manifested by oliguria, dry skin and mucous membranes, weakness, thirst and personality change) is to give water in excess of usual requirements. This may be done by infusion of 5% glucose in sufficient quantity to restore hydration.

If relatively more electrolyte is lost than water the plasma may be hypotonic and water will enter the cells to maintain isotonicity. This causes a drop in plasma volume. The urine volume may be normal until the condition is advanced. The plasma sodium and chloride fall. The clinical picture is one of a lack of thirst, apathy, muscular exhaustion, headache, syncope, and weakness. Corrective measures are predicated on the laboratory studies showing the deficiency and degree. The solution of choice usually is one with more sodium than chloride and is designed to restore electrolyte structure of both intra-cellular and extra-cellular water to

near normal levels. If the urine volume has been satisfactory there is occasionally a potassium deficit. The solution may be made by adding 700 ml. of 5% glucose in normal saline to 300 ml. 1/6 M sodium lactate solution. Potassium may be added if needed.

It is impossible to replace deficits of cellular electrolyte with sodium chloride and in many cases the concentration of extracellular electrolyte may remain abnormal or in an unstable state until cellular electrolyte has been restored. For example, alkalosis, in the presence of potassium deficit, may persist despite abundant available extracellular fluids and electrolytes. It is not usually realized that severe alkalosis due to chloride deficit tends to be accompanied by potassium deficiency. Hypopotassemia may occur when renal acidosis is too vigorously treated with solutions containing sodium. The excess sodium will enter the cells, displacing potassium which may be excreted. The intra-cellular sodium is unavailable to raise the low CO_2 combining power and the acidosis does not improve. If the clinical appraisal is not accurate the situation may get worse until potassium is given to enter the cell and replace the sodium which becomes free to form a satisfactory alkali reserve with the available bicarbonate. If a patient is edematous it is probable that renal conservation mechanisms for sodium are satisfactory. When the excretion of sodium chloride is poor due to reduced filtration, the excessive use of isotonic saline produces hypertonic extracellular water and may rapidly expand this compartment. Likewise the failure to restrict sodium in such patients may result in hypertonicity of the extracellular water. Solutions containing sodium (as bicarbonate or sodium lactate) may produce an excess of sodium which, by displacing intracellular potassium may cause dangerous hyperpotassemia[6].

The concentration of potassium in the serum of a patient with severe renal insufficiency may be normal, increased, or diminished, and no satisfactory explanation for these widely varied conditions is known[34]. Exchange resins have a place in edema control in occasional cases and may be used to absorb either potassium or sodium when this is desired. Various resins are available and one is chosen according to the type of substance which should be removed. Correction of hypopotassemia may precipitate tetany inasmuch as tetany does not occur at lower levels of a calcium in the presence of hypopotassemia.

When considerable calcium is lost in the urine, the use of Vitamin D will increase the gastrointestinal absorption of calcium. The use of alkaline substances will minimize the excretion of calcium in the urine. Bland states that forty per cent of adults who die in uremia manifest osteomalacia, with an increase in osteoblastic activity and microscopic changes in the bones[6]. Late in chronic nephritis, the phosphate is not excreted. Milk is a good source of phosphorus and should be restricted. Calcium gluconate or calcium lactate may be given by mouth or parenterally to raise the blood calcium level.

The treatment of acute tubular necrosis (lower nephron nephrosis) may be divided into three phases: (1) treatment of the shock by restoring the blood volume or correcting the shock mechanism, (2) treatment during anuria or oliguria, (3) treatment during the period of diuresis. The oliguric phase is often the most difficult to treat because of the narrow margin of safety. The protein, potassium, and sodium should be greatly restricted. Protein intake will augment azotemia. If tissue catabolism occurs that also will cause the NPN to rise. A diet with the emphasis on carbohydrate and fat is given. The intake of fluid and electrolyte in food must be carefully watched. Potassium accumulation in the plasma is a major danger during the oliguric phase. Hypertonicity of the extracellular fluid may dehydrate the cells.

The insensible fluid loss amounts to about 1000 ml. per day. About fifty mEq. of each of the sodium and chloride are also lost. This may be covered by mixing 335 ml. of five per cent glucose in normal saline with 665 ml. of five per cent glucose in water. If there has been much sweating, equal parts of five per cent glucose in normal saline with five per cent glucose in water may be given. It should be remembered that when the seasonal temperature is high or when fever is present, the insensible loss may be doubled or tripled. With heavy perspiration several liters of fluid may be lost. Fluid loss from diarrhea or vomiting should be estimated and added to the daily insensible loss. An amount of fluid equal to the urine volume must also be added to the calculated fluid intake[35].

If from the plasma and urine electrolyte studies the patient is found to be losing more chloride than sodium, chloride may

be given slowly as a one per cent solution of ammonium chloride in amounts of about 500 ml. per day. If the urine pH is less than five, more chloride is being lost than fixed base. If the urine pH is 7.5 or more, more cation is being lost than anion. If acidosis is present, 1/6 molar sodium lacate or one per cent sodium bicarbonate may be given by vein.

Inasmuch as many of the deaths in renal failure in acute tubular necrosis occur after the onset of diuresis, a day to day management of the electrolyte and fluid problem should be attempted. The deficiences should be corrected as clinical or laboratory studies indicate. A good standard textbook of medicine (Harrison's "Principles of Internal Medicine") should be consulted for calculations and details because the problem is too involved to discuss adequately here. A rule of thumb is that the more one can approximate the normal extracellular water electrolyte pattern, the less of a burden will be placed on the damaged kidney. If renal function has not been heavily damaged, normal saline may be given and the kidneys will reject cation or anion as is necessary to maintain good electrolyte balance.

Solutions may be prepared to contain relatively more chloride, sodium, potassium, water, or calcium, as the need may be and the reader is referred again to a late standard textbook of medicine or to Bland's monograph on "The Clinical Use of Fluid and Electrolyte."

Summary

Some of the pathologic physiology behind fluid and electrolyte disturbance in renal disease has been presented. Complete coverage of the problem was not attempted because of the vastness of the problem and because conflicting opinions still prevail on some aspects. If the physician intelligently approaches the problem of acute or chronic renal disease by allowing an adequate diet low in protein, and by proper attention to the water and electrolyte balances, as well as properly treating any systemic condition aggravating the renal disease, he may extend the useful span of life of many patients previously considered to be hopeless.

REFERENCES

1. Relman, A. S.: The Medical Management of Advanced Renal Insufficiency. M. Clin. N. Amer., 38: 1447-1460, 1954.

2. Van Slyke, D. D.: Renal Tubular Failure of Shock and Nephritis. Ann. Int. Med., 41: 709-738, 1954.

3. Richards, A. N.: Processes of Urine Formation (Croonian Lecture), Proc. Roy. Soc., London, S. B., 126: 398, 1938.

4. Walker, A.; Bott, P. A.; Oliver, J., and McDowell, M.: Collection and Analysis of Fluid from Single Nephrons of Mammalian Kidney, Am. J. Physiol. 134: 580, 1941.

5. Walker, A., and Oliver, J.: Methods for the Collection of Fluid from Single Glomeruli and Tubules of the Mammalian Kidney, Am. J. Physiol., 134: 562, 1941.

6. Bland, J. H.: The Clinical Use of Fluid and Electrolyte. W. B. Saunders Co., Philadelphia, p. 160-188, 1952.

7. Dock, W.: Proteinuria and the Associated Renal Changes, N. E. J. M., 227: 633-636, 1942.

8. Shannon, J. A.: Renal Tubular Excretion. Physiol. Review, 19: 63-93, 1939.

9. Shannon, J. A., and Ranges, H. A.: On the Renal Tubular Excretion of Creatinine in Normal Man. J. Clin. Invest., 20: 169-176, 1941.

10. Weisberg, H. F.: Respiratory Factors in Disturbance of Acid-Base Balance. Am. J. Clin. Path., 23: 1082, 1953.

11. Lakeside Laboratories, Inc.: Regulation of Acid-Base Balance: The Renal Control of Normal Ion Exchange, Diuretic Review, 3: 88-90, 1954.

12. Fourman, P.: Interpretation of Electrolyte Changes in the Blood, Brit. M. J., 1: 1144, 1954.

13. Pitts, R. F., and Alexander, R. S.: The Nature of the Renal Tubular Mechanism for Acidifyiug the Urine. Am. J. Physiol. 144: 239-254, 1945.

14. Pitts, R. F.; Lotspeich, W. D.; Schiess, W. A., and Ayer, J. L.: The Renal Regulation of Acid-Base Balance in Man. I. The Nature of the Mechanism for Acidifying the Urine. J. Clin. Invest., 27: 48, 1948.

15. Pitts, R. F.; Dorman, P. J., and Sullivan, W. J.: The Renal Response to Acute Respiratory Acidosis. J. Clin. Invest., 33: p. 82-90, 1954.

16. Pitts, R. F.: Mechanisms for Stabiliziug the Alkaline Reserves of the Body. Harvey Lect., 48: 172, 1952-1953.

17. Fitts, R. F., and Lotspeich, W. D.: Factors Governing the Rate of Excretion of Titratable Acid in the Urine. Am. J. Physiol., 147: 481, 1946.

18. Montgomery, H., and Pierce, J. A.: The Site of Acidification of the Urine Within the Renal Tubule in Amphibia. Am. J. Physiol., 118: 144, 1937.

19. Bland, J. H.: Role of the Kidneys in Regulation of Fluid and Electrolyte Balance. Am. J. Clin. Path., 23: 1070, 1953.

20. Nash, T. P., Jr., and Benedict, S. P.: The Ammonia Content of the Blood and Its Bearing on the Mechanism of Acid Neutralization in the Animal Organism. J. Biol. Chem., 48: 463, 1921.

21. Van Slyke, D. D.; Phillips, R. A.; Hamilton, P. B.; Archibald, R. M.; Futcher, P. H., and Hiller, A.: Glutamine as a Source Material of Urinary Ammonia. J. Biol. Chem., 150: 481, 1943.

22. Smith, H. W.: Lectures on the Kidney. Lawrence University Extension Division, U. of Kansas, 1943.

23. Bradley, S. E.: The Pathologic Physiology of Uremia in Chronic Bright's Disease. Chas. C. Thomas, Publisher, Springfield, Ill., p. 41-42, 1948.

24. Peters, J. P., and Van Slyke, D. D.: Quantitative Clinical Chemistry. Interpretatious, Vol. 1: 1041, Baltimore. Williams and Wilkins Co., 1946.

25. Schwartz, W. B.; Jenson, R. L., and Relman, A. S.: The Disposition of Acid Administered to Sodium Depleted Subjects: The Renal Response and the Role of the Whole Body Buffers. J. Clin. Invest., 33: 587, 1954.

26. Richards, A. N.: Direct Observations of Change in Function of the Reual Tubule by Certain Poisons. Tr. A. Am. Physicians, 44: 64, 1929.

27. Wiggers, C. J.: Present Status of the Shock Problem. Physiol. Rev., 22: 74, 1942.

28. Scarff, R. W., and Keele, C. A.: The Effects of Temporary Occlusion on the Renal Circulation of the Rabbit. Brit. J. Exper. Path., 24, 147, 1943.

29. Van Slyke, D. D.; Phillips, R. A.; Hamilton, P. B.; Archibald, R. M.; Dole, V. P., and Emerson, K., Jr., with Tech. Assistance of Stanley, E. G.; Becker, W. H., and Osserman, E.: Effect of Shock on the Kidney. Tr. A. Am. Physicians, 58: 119, 1944.

30. Phillips, R. A., and Hamilton, P. B.: Effects of 20, 60, and 120 Minutes of Renal Ischemia on Glomerular and Tubular Function. Am. J. Physiol., 152: 523, 1948.

31. Darrow, D. C.: Disturbances in Electrolyte Metabolism in Man and their Management. Bull. New York Acad. Med., 24: 147, 1948.

32. Darrow, D. C.: Body Fluid Physiology; Relation of Tissue Composition to Problems of Water and Electrolyte Balance. New Eng. J. Med., 233: 91, 1945.

33. Marriott, H. L.: Water and Salt Depletion (Croonian Lecture). Brit. M. J., 1: 245, 328, 1947.

34. Keith, N. M., and Osterberg, A. E.: The Tolerance for Potassium in Severe Renal Insufficiency: A Study of Ten Cases. J. Clin. Invest., 26: 773-782, 1947.

35. Vest, S. A., and Kelley, R. A.: Modern Treatment of Acuto Renal Failure. Jour. of Urology, Vol. 69, No. 1: 57, 1953.

CASE DISCUSSIONS

FROM THE UNIVERSITY OF LOUISVILLE ASSOCIATED HOSPITALS
NORTON MEMORIAL INFIRMARY

Recurrent Abdominal Pain

W. S. No. 150735, a 33-year-old married chemical operator, was admitted to the hospital on 9/25/55 complaining of left lower abdominal cramping.

The family history is non-contributory. Personal history revealed intake of one quart of whiskey and one case of beer per week from 1946 to 1952, but very little since. He smokes one package of cigarettes per day and is on regular day work. There is no exposure to harmful chemicals. Since discharge from the service in 1946, he has had considerable emotional stresses.

Past medical history reveals that prior to 1945 he was in his usual good health and at that time had his first episode of lower abdominal cramping accompanied by watery, urgent diarrhea without blood, the episode lasting for 3 weeks. Six months later, after patient had returned home from service, he had a similar episode accompanied this time by interscapular pain. He would have five to eight bowel movements per day and about two each night. Occasionally there were a few drops of blood and often there was mucus seen on the stool. The bowel movement relieved the abdominal cramping temporarily. Similar episodes have occurred from two to twelve times yearly and each lasting one to two weeks. In recent years patient has had vomiting with his episodes, but has never had hematemesis. Between these attacks he felt well and had about three bowel movements per day of normal character. He knows of no precipitating factors and usually limits his food intake. He was hospitalized elsewhere in 1950 and 1952 and states that he was diagnosed as having gastritis, enteritis and bronchitis. Upper GI in 1952 (Fig. 1) interpreted as constant deformity of the first portion of the duodenum due probably to extrinsic pressure on the bulb. Superficial duodenal ulcer possible. Gallbladder series showed normal gallbladder without evidence of stones.

In October, 1954, repeat upper GI series done elsewhere was reported as showing an active duodenal ulcer. At that time patient was having epigastric distress coming on several hours after a meal, characterized by a dull aching sensation with radiation directly into the back. The discomfort was relieved by food or alkali. There was no night pain. These episodes lasted for several weeks and occurred about two times per year since 1952. Patient would follow a moderate peptic ulcer regimen and symptoms would subside.

Present illness began ten days before admission when the patient had an onset of recurrent, mild, lower abdominal cramping situated principally on the left. The pain was relieved by food but returned one hour after meals. There was constant nausea but no vomiting and there was no change in bowel habit. There was some right upper quadrant discomfort although this was of mild degree. Because of an accompanying sore throat and because of concern over his condition, he

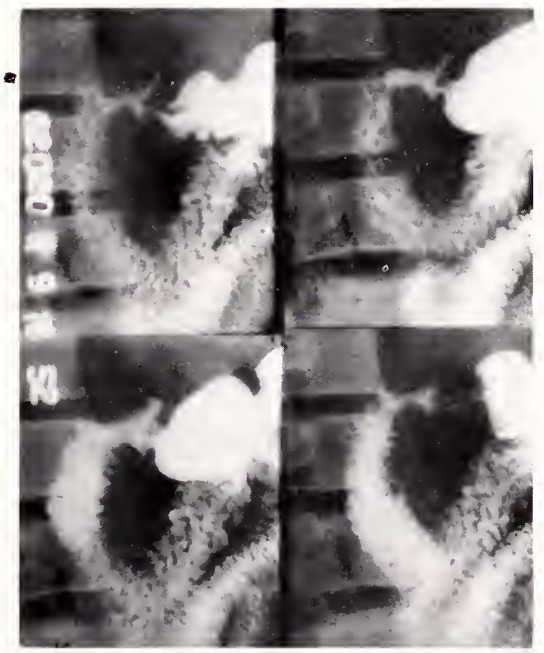


Fig. 1. Note constant deformity of bulb without evidence of ulcer crater.

remained at home from work although he was not incapacitated.

Physical examination revealed a well developed, well nourished white male in no acute distress. He appeared in good health, was quiet and cooperative. Temp. 98.6. Pulse 74. Respirations 18. Weight 170 pounds. The head, skin and lymph nodes were not remarkable. The mouth revealed gums and mucous membranes to appear healthy. The teeth were in good condition but dirty. All third molars were missing. The thyroid gland was not palpable. There was some increase in the AP diameter of the chest and excursions were full and equal bilaterally. Lungs were clear to auscultation and percussion. The heart was not enlarged and the apex beat was neither seen nor felt. There was regular sinus rhythm and no murmurs were heard. The abdomen was round and symmetric. There was no evidence of fluid and no excess tympany. With deep inspiration the liver could be palpated about one finger breadth below and parallel with the right costal margin. It was very slightly tender and smooth. The kidneys and spleen were not palpable. The descending colon was palpable and slightly tender. No other masses could be felt and there was no other tenderness. There were no abdominal wall hernias and no succussion splash in the epigastrium. Peristaltic sounds were not remarkable.

Examination of the back revealed no tenderness to percussion of the costovertebral angles and spinous processes. There was no muscular rigidity.

Rectal examination revealed the perianal skin and the sphincter tone to be normal. The prostate was smooth, symmetric and not enlarged. There were no masses nor tenderness. The external genitalia were normal.

Extremities and reflexes were not remarkable.

Laboratory examinations revealed urinalysis to be normal. RBC 5,328,000, hemoglobin 15 grams per 100 cc., color index .94, hematocrit 48 vols. %, WBC 6,200, Neutrophils 55, eosinophils 2, monocytes 4, lymphocytes 39. Blood VDRL negative. Serum calcium 5.2 millequivalents per liter. Caffeine gastric analysis revealed fasting residium of 38 cc., colorless and slightly mucoid, free acidity with Toepfer's was 15 millequivalents per liter. Maximum free acidity after caffeine was 64 millequivalents per liter, terminal free acidity (average of the 105 and 120 minute specimens) was 36 millequivalents per liter. This is interpreted as normal acidity and the response to caffeine not typical of duodenal ulcer. X-ray studies were as follows: following oral administration of Telepaque the gallbladder visualized well and there was no evidence of stones or other abnormality. Upper gastrointestinal examination revealed the esophagus normal. The stomach was high in position, walls flexible, peristalsis active and stomach emptied normally. There was no evidence of gastric ulcer or neoplasm. The mucosal folds of the stomach appeared normal. The duodenal bulb was relatively small and was deformed at all times. The lesser curvature side of the base was obliterated and the folds in the first and upper half of the second portion of the duodenum were somewhat heavy. There was no definite evidence of ulcer crater. The bulb was not irritable. (Fig. 2) The remainder of the small intestine was visualized and was not remarkable.

Barium enema revealed the barium to pass freely from the rectum to the cecum without evidence of obstruction or defects. The terminal ileum filled and showed a normal mucosal pattern. Cecum filled out well and showed normal contour. No diverticula were present and there were no areas of spasm. Post-evacuation films showed about 90% of the barium to have been evacuated and a normal mucosal pattern was seen throughout.

Intravenous urography following injection of 50% Neoiopax showed prompt and normal excretion of the contrast material by both kidneys. The kidneys and ureters and renal pelves were normal and the

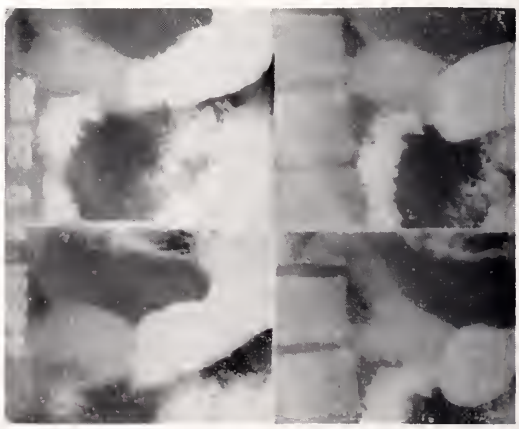


Figure 2. Note similarity of bulbar deformity with films taken 9/18/52. The relationship of the gall bladder to the bulb is demonstrated. There is no evidence of duodenal obstruction at the time of either examination.

bladder shadow was not remarkable. Photofluorograph of the chest revealed no abnormality.

Because of the patient's recurrent symptoms suggestive of disease of the pyloroduodenal segment and because of duodenal bulb deformity, an exploratory laparotomy was performed on Oct. 5, 1955, with a preoperative diagnosis of duodenal ulcer.

Question: Considering all of the preoperative clinical, x-ray and laboratory data, was this case felt to be unquestionably one of duodenal ulcer?

Arthur Schoen, M. D.: The preoperative diagnosis was presumptive. Clinically, the symptoms were suggestive of peptic ulcer by their pain-food-relief pattern, their periodicity and the description of the type of abdominal discomfort. However, the location of discomfort in the lower abdomen is unusual for peptic ulcer. This patient complained more of left lower quadrant pain on this admission than of epigastric discomfort, and therefore gastroduodenal disease would be unlikely the cause for his presenting symptom. The radiologist did not see an ulcer crater, and therefore a presumptive diagnosis of duodenal ulcer would have to be based upon findings which are commonly associated with active ulcer, namely, irritability and deformity of the bulb, coarsening of mucosal folds and changes in gastroduodenal motility. In this case, an unequivocal diagnosis of duodenal ulcer was not made by the radiologist just prior to surgery, although he did state that he believed the patient had previously had the disease.

The caffeine gastric analysis was interpreted as normal acidity, and the response to caffeine was not typical of duodenal ulcer. My experience with this test is similar to that of Roth who reported an accuracy of 92% in duodenal ulcer patients (whether active or inactive at the time the test is performed) and an accuracy between 86 and 92 percent in non-ulcer subjects. If the caffeine gastric analysis is properly performed and if the specimens are satisfactory for analysis, which they usually are, then this test is capable of making a diagnosis of the duodenal ulcer diathesis in about 90% of instances, and this is comparable to the diagnostic accuracy of a well-trained and experienced gastrointestinal radiologist.

In this particular case, surgery probably would not have been performed if the x-ray films had not shown persistent deformity of the duodenal bulb. Unfortunately, internists and surgeons alike have accustomed themselves to look to the radiologist for the final diagnosis of duodenal ulcer, and this almost to the exclusion of all other findings. It is not enough to rule in or out the presence of peptic ulcer, but one must attempt to explain the cause for symptoms compatible with ulcer when none is present. A deformed bulb may be produced by any one of several factors including hypertrophy of Brunner's glands, pedunculated gastric polyp, duodenitis, external pressure from the gall bladder or liver or by pericholecystitis adhesions or congenital bands as well as by carcinoma of the pancreas and rarely by primary cancer of the duodenum. In the absence of a demonstrable crater, it is very difficult and often times impossible to make an unequivocal diagnosis of the cause for the deformity. For this reason, one is justified in recommending exploratory laparotomy in the presence of a deformed bulb providing, of course, that symptoms referable to this area are present.

Question: What was found at surgery?

R. Arnold Griswold, M.D.: Upon entering the peritoneal cavity no free fluid was found, all organs were examined and no abnormality was found within the duodenum. No scarring was evident. From the anterior surface of the duodenum in its middle portion, there were thin, membranous, non-vascular adhesions which extended to the fundus of the gallbladder. The remaining small intestine was examined and no abnormality was found. The membranous bands were lysed and the abdomen closed. The postoperative course was not remarkable and the patient was discharged on the fifth postoperative day.

Question: Are congenital bands connecting the duodenum and gallbladder common?

Dr. Griswold: There is a universal fold of peritoneum running from the ampullary portion of the gallbladder and cystic duct along the edge of the duodenohepatic ligament to the duodenum. Hypertrophy or misplacement of this fold of peritoneum, such as to produce constricting band, is extremely uncommon. According to Babcock's Surgery, it is known in such cases as Harris' bands.

Question: What is the incidence of duodenal bands or veils?

Gerald Peterson, M.D.: Duodenal bands or veils have been found in autopsies in as high an incidence as 80%. Such bands are usually very thin and filmy and are

not of clinical importance, whereas, in a very rare instance a heavier band causes actual obstruction of the duodenum. These bands may occur in accompaniment of abnormalities of rotation of the intestine or alone. Only a fraction of 1% of individuals show the rare type of band which has been found to cause obstruction in the duodenum.

Question: Do bands usually produce duodenitis or other acquired pathology such as cholecystitis or duodenal ulcer?

Dr. Griswold: Not to my knowledge.

Question: Is surgical correction usually permanent?

Dr. Griswold: Correction should be permanent if the band is completely divided and allowed to retract. The only sure way that I know of determining whether division of the band had produced the desired therapeutic result, and whether it is going to be permanent, is close observation of the patient for a period of several years, with x-ray findings showing correction of the pre-existing duodenal deformity.

Question: Are duodenal bands easily recognizable by x-ray?

Dr. Peterson: In infants or young children where duodenal bands are sometimes found to cause obstruction there is usually no problem in their recognition. The duodenum may show obstruction in the region of the superior duodenal flexure or half way down along the descending limb of the duodenum where the transverse mesocolon crosses the duodenum. Rarely the bands occur in the transverse portion of the duodenum and, in this location, are often associated with abnormalities of rotation of the intestine. The outstanding finding in such cases is obstruction of the duodenum with dilatation proximal to it. The very filmy bands are sometimes found between the duodenum, gall bladder, liver or hepatic fluxure of the colon and probably do not cause easily recognizable duodenal deformities. Some of these bands that are found at autopsy may be the result of adhesions that have formed between the duodenum and neighboring structures, and adhesions are known to cause distortion of the duodenal bulb. It is sometimes possible to recognize distortion and in this case in question I believe that one must conclude that the duodenal bulb is distorted slightly as the result of the duodenal band. This case in question exemplifies the difficulty that we had in recognizing the band as the cause of the distortion since healed duodenal ulcers cause changes in the contour of the duodenal bulb which closely resemble the slight distortion caused by the band.

Dr. Schoen: This patient was last seen on November 5, and was asymptomatic. It will require follow-up over a several year period before we can decide that the patient is improved following his surgery.

The subject of duodenal bands was given much attention during the first thirty years of this century. During that period, radiologists attempted to correlate clinical symptoms with x-ray findings due to bands, and there can be little doubt that even in the adult these bands may produce symptoms of obstruction. However, the high incidence of bands in persons known to have no symptoms and no x-ray findings of distortion or obstruction, would lead us to believe that these anatomic structures are usually without clinical significance. The presence of duodenal bulb deformity in a person with upper gastrointestinal symptoms of sufficient degree and duration is indication for treatment of duodenal ulcer providing other organic causes have been excluded. If medical management is unsuccessful, then laparotomy is indicated, and if bands are present in the absence of other pathology, acute or chronic, then surgery should be limited to division of the bands, and definitive ulcer surgery not carried out.

SPECIAL ARTICLES

SOCIAL SECURITY—BIG ISSUE IN '56

Every physician who is conscious of his duties as a citizen will now be taking an active interest in a timely issue which the American Medical Association considers of great importance—not only to the medical profession, but to all of the American people.

That issue is HR 7225, a bill passed by the United States House of Representatives last summer near the end of the Congressional session. This bill, known as the Social Security Amendments of 1955, was first rushed through the House Ways and Means Committee without public hearings. Then it was passed in the House, by a vote of 372 to 31, under a suspension of the rules which barred amendments and limited debate to 40 minutes. The Senate Finance Committee, however, refused to take hasty action on a bill of such major importance. After hearing the many serious questions raised by Mrs. Hobby, then Secretary of the Department of Health, Education and Welfare, the Committee decided to hold extensive public hearings during the second session of the 84th Congress.

Just what is this legislation that appears to be so politically attractive to individuals with an eye on the 1956 elections? Why was the House majority leadership so determined to avoid open hearings and normal debate? Let's take a brief look at the main provisions of the bill.

This is the legislation which would lower the Social Security retirement age for women from 65 to 62; extend monthly benefits for permanently and totally disabled children beyond the age of 18; expand compulsory social security coverage to all self-employed professional groups except physicians, and raise social security taxes over and above the increases already scheduled for the next twenty years. Those provisions alone demand careful study of their effects on the philosophy, scope and financial stability of our social security system.

The most controversial section of the bill, however, is the one which would make permanently and totally disabled persons eligible to receive their social security retirement benefits at age 50 instead of 65. It is this section which is of particular concern to the medical profession. It is of far greater concern than the question of voluntary or compulsory coverage of physicians under the social security system. That is a separate issue which we are not discussing in this editorial. The plan for a national system of permanent and total disability benefits has far more serious implications for medicine and the nation.

It raises questions such as these: Is there any real need for a federal program? What are the facts on permanent and total disability? Won't this duplicate or overlap existing programs of assistance and rehabilitation? What effect will cash handouts have on a patient's incentive to be rehabilitated? Won't this extend federal control over physicians?—and, finally—How will this affect the future of medical practice? Will this lead, step by step, to the lowering and eventual elimination of the age-50 eligibility requirement; then, cash benefits for the dependents of those who are permanently and totally disabled; then, a temporary disability benefits program; then, cash benefits or direct government payments for hospital or medical costs, and then, ultimately, a full-fledged system of government health insurance?

These are but a few of the many grave questions which already have been raised concerning this legislation. As physicians, we must be concerned over the medical aspects of the problem. As citizens, we also must be concerned over the trends and implications in the never-ending expansion of our social security system. The minority report of the House Ways and Means Committee expressed it this way:

"We do not believe that our committee has discharged its obligation to either the Congress or to the American people by its brief and closed-door consideration of this vital legislation. We have sought to point out the grave social and economic implications of the bill. We have dwelt at some length with the staggering ultimate costs

(Continued on page 78)

The Jerman M. Baker Memorial Meeting of the Kentucky State Medical Association

Columbia Auditorium, Louisville, Kentucky, September 26, 28, 1955

Digest of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Charles A. Vance, M. D., Lexington, Speaker of the House, Presiding

(Continued from December Journal)

REFERENCE COMMITTEE NO. 4

T. O. Meredith, M.D., Chairman

Reports on Miscellaneous Business

Committee to Study the Constitution and By-laws

This report sets forth changes in the Constitution and By-laws as recommended by the Committee*.

As stated by the Chairman of the Committee to Study the Constitution and By-laws, at the first meeting of the House of Delegates the amendments to the Constitution, and to the Articles of Incorporation, and the amendments to the By-laws, were all presented to the House of Delegates at its 1954 Annual Session. Their report was sent to each county medical society two months prior to the 1955 Annual Meeting.

We, therefore, present them at this time for adoption.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee to Study the Constitution and By-laws be adopted.

Mr. Speaker, therefore, I move the adoption of all the amendments to the Constitution as set forth in the report for adoption.

Motion was seconded and carried that the amendments to the Constitution be adopted.

The amendments to the Constitution carried by a 2/3 vote of all delegates registered at the Annual Session.

Mr. Speaker, therefore, I move the adoption of all the amendments to the By-laws, as set forth in this report.

Motion was seconded and carried that the amendments to the By-laws be adopted.

The Amendments to the By-laws carried by a 2/3 vote of the delegates at the Annual Session.

---

* Ed Note: Complete copy of Constitution and By-laws, as amended, appears in this issue of the Journal of the KSMA.

Dietetic Committee

The report contained information on the weight control program which was carried on in 12 counties.

This report deals with weight control projects in Kentucky.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Dietetic Committee be adopted.

Emergency Medical Service Committee

The report gives several recommendations as to how the medical profession can better prepare itself in civil defense matters.

This report was read to the House of Delegates at its first session and contains several recommendations which we think are worth repeating:

"(1) That all doctors in the State of Kentucky be issued a questionnaire in regard to his qualifications for the type of work he is now practicing, and for any secondary specialty or interest.

"(2) That a survey of all schools, churches, and other public buildings should be made in regard to the square feet of floor space, cafeteria facilities, and toilet facilities.

"(3) The blood type of an individual should be carried on a card which is uniform throughout the state. This information may be secured from existing hospital records, future blood typings in hospitals, and from voluntary blood typing in approved facilities."

The Reference Committee commends the Committee on Emergency Medical Service for their excellent work.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on Emergency Medical Service be adopted.

Report of the Advisory Committee to Selective Service

The Committee reports that it has spent a relatively quiet year principally due to the reduction of the needs of the military and the re-

quirements being met to a large degree by recent medical and dental graduates.

This report states that this Committee has been relatively quiet this year and feels that very few lay doctors would now be needed for military service if: (1) better utilization were made of the regular medical officers; (2) a reduction were made in medical services provided non-military personnel; and (3) greater incentive could be offered professional folk for going into military service. The Advisory Committee to Selective Service does not favor the "Doctor Draft."

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and passed that the report of the Advisory Committee to Selective Service be adopted.

Board of Directors, Kentucky Physicians Mutual, Inc.

The report relates the rapid growth of the plan, attributed in a large part to the urgent need and demand for prepaid medical care and the fact that the Blue Shield plan has provided this at the lowest possible cost. Other items discussed in the report are: enrollment; operating data; financial condition; actions taken by the Board of Directors; Annual Conference of Blue Cross and Blue Shield plans, and the participation of physicians.

This report deals with the splendid growth and financial condition of the Kentucky Physicians Mutual. The contents, graphs and charts should be very interesting to all members of the KSMA. The Committee states, "To each member of the KSMA who has in any way helped to contribute to the growth and success of the Kentucky Physicians Mutual, Inc., the Board of Directors wishes to express its sincere gratitude. It is our hope that our plan may continue to render ever increasing service to the medical profession of our state."

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Board of Directors of the Kentucky Physicians Mutual, Inc., be adopted.

Professional Relations Committee

The Committee reports that it has received approximately 12 complaints against individual doctors and the profession as a whole.

This report states that this Committee has been fairly active during the year and has received approximately 12 complaints against individual doctors and the profession as a whole.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Professional Relations Committee be adopted.

Rural Health Committee

The report states that three meetings of this committee have been held. The Fifth Annual Rural Health Conference was held in June of 1955 and was a success. The Chairman spoke at the National Rural Health Conference in Wisconsin this year, and at that time presented an invitation for the Conference to meet in Kentucky in 1957, and the invitation was accepted.

This is an excellent report and the Reference Committee wishes to commend the Committee on Rural Health for its excellent work. The Committee on Rural Health requests that more and more physicians will join in this program and increase its activities in the future. The program for the 1956 Rural Health Conference has already been arranged and it is thought that greater progress will be made next year than any previous year. The National Rural Health Conference will be held in Louisville, Kentucky in 1957.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on Rural Health be adopted.

Cancer Committee

The Committee reports that no meeting was held during this associational year.

The Cancer Committee did not meet; therefore, there is no report.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Cancer Committee be adopted.

Advisory Committee on Mental Hygiene and Mental Institutions

The report describes steps taken by this Committee and the Department of Mental Health in improving our program for mental hygiene and mental institutions. The Chairman will attend the Conference of Mental Health Representatives of State Medical Associations, sponsored by the AMA Council on Mental Health in November.

This report is a summary of the program of activities for the year 1954-55, and shows the progress that has been made by this Committee in improving our mental hygiene and conditions in our mental institutions.

We wish to commend the excellent work of the Commissioner of Mental Health. The Reference Committee feels that it is an excellent report and should be read in its entirety by every member of the House of Delegates.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on Mental Hygiene and Mental Institutions be adopted.

Advisory Committee on Public Health

The report covered activities in connection with "Immunization Week," sponsored by the Association, through this Committee, for the second consecutive year. Plans for developing a cooperative accident prevention education program were discussed.

This committee reports various activities connected with "Immunization Week in Kentucky," and has requested that the Association's Education Campaign Committee favorably consider permitting immunization to be the theme of its 1956 exhibits at the KEA meeting and the Kentucky State Fair. They have held several meetings in connection with the accident prevention program with the State Department of Education and feel that their work has been well received and well worthwhile.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on Public Health be adopted.

Advisory Committee to the Blue Cross

It was reported that the yearly meeting of the Advisory Committee had been held and an outline of objectives of the organization and problems confronting it was presented for discussion.

The Committee held one meeting in September, 1954. Policies of the previous year were continued.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee to the Blue Cross be adopted.

Committee on Scientific Exhibits

The Committee reports that all 14 exhibit spaces were filled, and that six requests for space from voluntary health organizations had to be turned down.

The Committee regrets that it was necessary for them to turn down a number of requests for space and reports that they did accept 14 scientific exhibits, which are now on display at the front entrance to the building.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee on Scientific Exhibits be adopted.

McDowell Home Committee

The report consists of a financial statement for the year July 1, 1954 to June 30, 1955 and plans for the acquisition of adjoining property.

This report contains the financial statement for the year July 1, 1954 to June 30, 1955 showing that the McDowell Home is in good financial condition and has been operated in a very commendable manner. It also deals with the acquisition of adjoining property for the purpose of restoring the old pharmacy building adjoining the McDowell Home, and removal of the undesirable property adjoining. The funds for this purpose are being donated by the Manufacturing Pharmaceutical Houses of the United States and we wish to commend the National Pharmaceutical Association for their generosity.

The report also requests that the KSMA continue its annual appropriation of $1,500.00 for the upkeep and operation of the McDowell Home, and they wish to thank the Woman's Auxiliary to the Kentucky State Medical Association for its fine cooperation and the work that it has done.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the McDowell Home Committee be adopted.

Resolution on Definitions and Policy Relating to Practices of Medicines

Mr. Speaker, we have a resolution on Definitions and Policy Relating to Practices of Medicine, which reads as follows:

WHEREAS, the American College of Surgeons has seen fit to castigate, through the medical and non-medical press, certain unnamed members of the medical profession because of alleged "Fee Splitting" and "Ghost Surgery":

WHEREAS, the House of Delegates of the AMA has, with some reservations, followed the lead of the American College of Surgeons:

WHEREAS, the KSMA has given seeming assent to the contentions of the American College of Surgeons:

WHEREAS, a number of clinics of our country, in which corporate medicine is practiced, reimburse physicians of the clinic on a salary basis, with dividends to stockholders from earnings in excess of salaries and expenses:

WHEREAS, some physicians, particularly Pathologists and Roentgenologists are employed by private hospitals on such bases that the employing hospitals profit through the professional services of the employed physicians:

(1) RESOLVED, that the KSMA formulate definitions of "Fee Splitting" and "Ghost Surgery."

(2) RESOLVED, that the KSMA formulate simple understandable rules for the guidance of its members, without discrimination toward any individual or group of individuals.

(3) RESOLVED, that the action of the KSMA be transmitted to the AMA and to the Kentucky Chapter of the College of Surgeons.

The Reference Committee recommends that the President of the KSMA refer this Resolution to the proper committee of the Association for its action.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that this resolution be referred by the President to the proper committee for study.

Formation of Two Nominating Committees in the Kentucky State Medical Association

Mr. Speaker, we have a Resolution on the Formation of Two Nominating Committees in the KSMA, which reads as follows:

WHEREAS, it has been found in general elections that the best interest of government has been promoted by free choice of the electorate between opposing candidates for office, and

WHEREAS, in several instances in previous years the choices of the single nominating committee did not reflect the true choices of the sections involved, and

WHEREAS, the only redress which the dissenting groups had to bring their choice before the electorate was by open nomination from the floor with resulting undesirable conflicts of personalities, injuring of personal feelings, etc., and

WHEREAS, such personal differences, etc., can only result in disunity of this Association.

THEREFORE, BE IT RESOLVED, that a change in the By-laws be made to provide for the formation of two nominating committees, to be elected by the House of Delegates in the same manner as the one Nominating Committee is now elected; and that each of these Nominating Committees present a group of candidates for the several officers of this Association to be presented to the House of Delegates to be voted upon in the same fashion as is now provided.

The Reference Committee feels that this Resolution for a change in the By-laws is not necessary or appropriate at this time as there has not been a sufficient length of time for the present procedure to be thoroughly tested and tried. The Reference Committee further feels that this change in procedure would tend to inject into the Association a brand of politics which would be undesirable; therefore, we recommend that this Resolution not be adopted.

Mr. Speaker, I move that this section of the report be adopted.

Motion was seconded and carried that this section of the report be adopted.

Resolution on the Infringement of the Public Health Department on Private Medical Enterprise

Mr. Speaker, we have a Resolution on the Infringement of the Public Health Department on Private Medical Enterprise, which reads:

At a meeting of the Henry County Medical Society on Monday, June 27, 1955, the following resolution was presented and unanimously approved:

It is felt that the thoughts of the members of this Society coincide, in general, with the thoughts of the great majority of practitioners throughout this country; that is, that we are placidly watching the camel of state medicine put his head and shoulders into the tent of private medical practice.

We refer specifically to two items in our own county:

Item 1. The practice of offering free immunization of any type to the general public. Let us make it clear in the beginning that our complaint is not an economic one. The first reason for objection is that this is a wedge being driven into the log of private medicine, a wedge which creates an opening to make it easier for the next and larger wedge to be driven in place. The second reason, and of tremendous importance, is that the family physician is not in a position to know what immunizations his patients have received from the Health Department. Therefore, when the patient presents himself for boosters, the physician is at a loss as to what to give. Let us give an example: A nine year old child is brought in with a puncture wound of the foot received by stepping on a nail in the stable. The physician inquires of the parents as to whether the patient has had tetanus immunization; the answer is that the child had some shots from the health nurse last year, but they don't know what the shots were. This frequently occurs, and the parents do not know. For the safety of the patient the physicians must give a prophylactic dose of tetanus anti-toxin, with the attendant danger of horse serum sensitivity, and the disadvantages of conferring only temporary immunity. This is just one example of many confusing problems that are encountered.

Let us state that no person in this county is refused immunization because of lack of funds by any private practitioner in this county. We still do a majority of the immunizations for the indigent patients, and the "able-to-pay" patients go to the Health Department for their "shots."

It is definitely our feeling that the giving of immunizations is not in the domain of the Health Department, and that the administration and recording of immunizations is the function of the family physician, and that the function of the Health Department in this instance, is purely educational.

Item 2. Pre-school physical examinations by Health Department Personnel. Here again let us state that our complaint is not an economic one. The basic principle behind the pre-school exam is a sound one, however, its application, at present, in a majority of the communities of the state can definitely be detrimental to the good of the subject students. We refer to the practice of lining up the student body, or grades concerned in a school, looking in their throat and listening to their heart and calling it an examination. The parent is lulled into a false sense of security by the record that the child is physically sound.

The purpose of the required pre-school exam is to find and correct physical defects or detect disease in its early stages and increase the chances of cure. A careful physical examination, in the privacy of the physician's office, and with the patient stripped, a fluoroscopic examination of the chest, patch test for tuberculosis, and a careful check of the immunization status, with the administration of the needed vaccines, is the minimum with which we should be satisfied if we would label it a pre-school examination.

We do not feel that the use of a senior medical student, employed by the Health Department, to conduct the pre-school examination, will in any way meet the standard minimum requirements set out above.

In some of the years past, the pre-school examination in the required grades in this country have approached 100%. These examinations were done in the office of the family physician, indigent and "able-to-pay" alike, defects were found and remedied when possible. In these years where 100% participation was approached, the credit goes entirely to the

county educational personnel who demanded that the examination be done before the student could continue in school.

Here again, we feel that the administration of this program is entirely the function of the Department of Education and the private physician, and that the function of the Health Department is purely one of education.

The Reference Committee feels that this is more a statement of the views of the members of the Henry County Medical Society, as well as the views of many of the members of the State Medical Association, but it does not make any specific recommendation.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and motion carried.

Mr. Speaker, we have three resolutions concerning the acceptance and distribution of the Salk polio vaccine, which were considered as a group by Reference Committee No. 4. They read as follows:

"RESOLVED that we approve the action taken by the Council in accepting the present allotment of polio vaccine from the Federal Government, but that we vigorously oppose accepting any more polio vaccine in the future except for the medically indigent."

"Be is resolved that the Campbell-Kenton County Kentucky Medical Society is opposed to the entirely free distribution of Salk-anti-polio vaccine as approved by the Council of the KSMA in advisory capacity to the Kentucky State Board of Health on August 25, 1955 and on September 8, 1955.

"This is a socialistic measure and be it resolved therefore that the House of Delegates rescind the action of the Council in this matter and distribution be made on a 30% indigent and 70% pay basis."

"WHEREAS, The intent of Congress in Public Law No. 377 is to provide polio vaccine for the indigent in each state and not for all persons within a given age group, and

"WHEREAS, The Law does not provide for a means test to determine who is indigent (indigent considered to be less than 20%), thereby permitting Kentucky to accept federal money sufficient to purchase all the vaccine needed for a given age group, and

"WHEREAS, In the light of present information there is positive evidence that the vaccine not accepted with federal money can be released immediately through regular commercial channels for those who are not indigent, and

"WHEREAS, In the interest of the patient, normal and regular methods of obtaining and administering the vaccine would result in less cost and more desirable service, and

"WHEREAS, It is necessary for the physicians of Kentucky to act in the best interests of their patients, to maintain the most satisfactory physician-patient relationship and to preserve the American Free-Enterprise System, therefore

"BE IT RESOLVED, That the House of Delegates of the KSMA advise the State Department of Health to purchase no more than Thirty per cent of the total vaccine allocated for Kentucky or the amount now purchased, if greater, for indigents, and

"BE IT FURTHER RESOLVED, That the remaining amount of vaccine under the allocation program be distributed at once through available commercial channels."

In a three-hour session on September 27th, Reference Committee No. 4 heard every phase of the problem presented and everyone who had anything to say on this subject was recognized and the opinions were very diversified, going all the way from rejecting entirely the vaccine to accepting it as recommended by the Council. The Reference Committee in its session discussed the matter thoroughly and wishes to recommend to the House of Delegates:

That the KSMA, through its House of Delegates, refuse to accept any funds allocated by the Federal Government as proposed in Public Law 377, as passed by the last session of Congress;

That the KSMA will furnish all the vaccine services through their local physicians and local county medical societies, to all indigent people in the state of Kentucky, without charge, and that all other people who require immunization may receive the vaccine from their own private physician at a cost not to exceed the cost of the vaccine plus their normal office fee for administering same;

That all practicing physicians participating in the immunization program contribute to a central fund from which any of these physicians may draw vaccine from his allocation for his indigent patients;

That when this policy has been determined, the vaccine can be released for immediate use from all pharmaceutical houses;

That the President of the KSMA appoint a committee to expedite the immediate administration of this program.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and a thorough discussion followed.

The Chairman of Reference Committee No. 1 was then requested to re-read that section of the Committee report having to do with proposed action on the Salk Polio vaccine matter.

The Chairman of Reference Committee No. 4 withdrew his motion that the section of the report of Reference Committee No. 4 relating to the polio vaccine distribution matter be adopted by the House, in order that the recommendation of Reference Committee No. 1 might be presented first for a vote. The second to the motion was also withdrawn.

At this time, the Speaker pointed out that he would rule that an affirmative action on the recommendation of Reference Committee No. 1 would eliminate action on the related subject as presented by Reference Committee No. 4.

Mr. Speaker, I, Chairman of Reference Committee No. 1, move the adoption of the report of the Council with the amended portion added by the Reference Committee pertaining to the Salk Vaccine.

Motion was seconded and after further discussion the House of Delegates voted to accept the report of the Council, as amended by Reference Committee No. 1.

It was moved and seconded that this action be made a unanimous action by acclamation and the motion carried.

Mr. Speaker, I, Chairman of Reference Committee No. 1, move that the report of Reference Committee No. 1 be accepted as a whole.

Motion was seconded and carried that the report of Reference Committee No. 1 be accepted.

REFERENCE COMMITTEE NO. 1

E. M. Howard, M.D., Harlan, Chairman
Rankin C. Blount, M.D., Lexington, Vice-Chairman
Carlos Fish, M.D., Louisville
C. F. Long, M.D., Elizabethtown
Wendell V. Lyon, M.D., Ashland

Mr. Speaker, I, Chairman of Reference Committee No. 4 move that the report, as amended, of Reference Committee No. 4 be accepted as a whole.

Motion was seconded and carried that the report of Reference Committee No. 4 as amended, be accepted.

REFERENCE COMMITTEE NO. 4

T. O. Meredith, M.D., Harrodsburg, Chairman
Everett H. Baker, M.D., Louisville
W. E. Becknell, M.D., Manchester
Robert S. Dyer, M.D., Louisville

REFERENCE COMMITTEE NO. 5

Roy H. Moore, M. D., Chairman

Reports on Miscellaneous Business

The Chairman reported that he had been requested by members of the delegation from Jefferson County to ask for the floor in their behalf for the purpose of withdrawing two resolutions which had been presented.

It was moved, seconded and carried that permission be granted the Jefferson County Medical Society delegation to present this matter.

Advisory Committee to the Editor

The report dealt chiefly with the efficient functioning of the various departments of the Journal, the able leadership of these departments, satisfactory increase in advertising and an expression of thanks from the Committee to the Editor and Managing Editor for their cooperation and assistance.

This report was studied by Reference Committee No. 5 and approved as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee to the Editor be adopted.

Geriatrics Committee

This Committee recommends the following:

1. A Kentucky State Geriatric Society be formed as a component part of the American Geriatric Society.
2. Seminars in Geriatrics be a part of the Annual Scientific Assembly of the KSMA.
3. Teaching of courses in Geriatrics be promoted at the University of Louisville.
4. State Advisory Committee be appointed by the President of the KSMA or the State Geriatric Society if such is formed to confer with National Group to assist industry, labor, and physicians, private and industrial, in the maintenance of the health of the older worker.
5. Program of lectures for social groups and clubs for development of hobbies, crafts, entertainment, and education for companionship and security.

The report of the Geriatrics Committee was studied by Reference Committee No. 5 and is approved as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Geriatrics Committee be adopted.

Insurance Committee

A resume of items discussed at the May meeting of the Committee were listed in the report. Discussed at length was the Association's responsibility to voice its opposition to the many socialistic bills before Congress, the filling out of insurance forms, standard claim forms, abuse of hospital insurance, and the proposed amendments to the Social Security Act, which will provide cash benefits to certain Social Security beneficiaries who are permanently and totally disabled.

This report was studied by Reference Committee No. 5 and approved as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Insurance Committee be adopted.

Pharmacy Committee

This Committee held no meetings during the past year.

There were no called meetings and no referred material for the Pharmacy Committee during the past year. The report of this Committee is approved as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Pharmacy Committee be adopted.

Committee to Study Medical Examiner System

This Committee held no meetings during the past year.

This Committee had no meeting and the report is approved as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Committee to Study the Medical Examiner System be adopted.

Veterans Committee

Three recommendations were made by this Committee: 1. Adjustments and approved fee schedule for Veterans Hometown Medical Care proposed; 2. Discussed and answered an inquiry concerning hometown fees; 3. Talk and slides on veterans care to be given by the field secretary approved. Other items in the report were: three Committee members are scheduled to attend a liaison committee in Indianapolis, September, 1955; treatment of service connected illnesses; and an appeal from the Committee that all veterans' physicians join the American Legion or some other veterans organization and take an active part.

This report was studied by Reference Committee No. 5 and approved as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Veterans Committee be adopted.

World Medical Association Committee

The Committee encourages all physicians in Kentucky who can join this organization which, joined with the United Nations, makes a strong organization for the advancement of medical science throughout the world.

This Committee held no meeting, but wishes to encourage all physicians in Kentucky who can, to join this worthwhile medical organization. The report of this Committee is approved as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the World Medical Association Committee be adopted.

Advisory Committee on Industrial Medicine and Surgery

The Committee reports that the division of Occupational Health of the Kentucky State Health Department has increased its personnel and now has a director; the Jefferson County Medical Society now has an Industrial Health Committee functioning and that due to an increase in the industrial population in Kentucky, there has been an increase in both nurses and doctors in the field of industrial health.

The report of this Committee is approved as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on Industrial Medicine and Surgery be adopted.

Advisory Committee on Tuberculosis

The report contains three recommendations made by the committee at its July, 1955 meeting, in an effort to improve conditions in the State Tuberculosis Hospitals in accordance with the State Tuberculosis Hospital Commission.

Reference Committee No. 5 approves the report of the Advisory Committee on Tuberculosis.

Section 1. The Committee recommends the establishment of locked facilities as referred to in Section 1 of this report.

Section 2. The Committee approves the method of sterilization as recommended by the Committee on Tuberculosis.

Section 3. The Committee approves the recommendation that the district hospitals of the State Tuberculosis Hospital Commission conduct yearly or semi-yearly medical seminars on diseases of the chest for physicians in the respective districts.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee on Tuberculosis be adopted.

Advisory Committee to Woman's Auxiliary

The Committee held no meeting during the year.

Reference Committee No. 5 approves the report of this Committee as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Advisory Committee to the Woman's Auxiliary be adopted.

Committee on Technical Exhibits

It was reported that four booths have been added to the exhibits hall, making a total of 65 available for rental. Due to increasing cost of maintenance and setting up of these booths, rental, etc., the rental was increased, and all were promptly engaged when prospectives were written last spring.

The report of this Committee is approved as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that

the report of the Committee on Technical Exhibits be adopted.

Report of the Rural Kentucky Medical Scholarship Fund

The total number of loans that have been made or are in the process of issuance is 245, for a total sum of $197.896. It was pointed out that unless additional funds become available from some source before the beginning of the 1956-57 school year, it will be necessary to sharply curtail the program. The report contained additional information on the financial status of the fund and pointed out that a total of 36 physicians, who have been assisted by the fund, have entered practice in the rural areas of our state.

Reference Committee No. 5 has carefully studied this report and recommends its approval. The Committee would like to call attention to the need for funds for this Committee to continue this very worthy cause.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Rural Kentucky Medical Scholarship Fund be adopted.

Resolution on Importance of Administrative Continuity to Effective Progress In State Mental Hospitals

Mr. Speaker, we have a resolution on the Importance of Administrative Continuity to Effective Progress in State Mental Hospitals, which reads:

WHEREAS, the public mental hospitals have made tremendous advances in recent years in this Commonwealth with the establishment of sound administrative policies, the securing of qualified personnel—psychiatrists, nurses, attendants—in all hospitals, the inauguration of realistic research and treatment programs with establishment of psychiatric residency training, and

WHEREAS, foundations have been laid for expansion of active preventive program of mental hygiene,

WHEREAS, the public problem of the mentally sick, combining administrative complexities with the technical application of modern psychiatry, renders a mental health problem peculiarly vulnerable to the shifting winds of political favor, and

WHEREAS, in the past in this Commonwealth we have seen such distastrous consequences to our state mental health program with changing administrations, commissioners, and policy,

BE IS HEREBY RESOLVED by the delegates of the KSMA here assembled that the considered and sound achievement of the Department of Mental Health under the commission of Frank M. Gaines, M.D., be enthusiastically approved, and

BE IT FURTHER RESOLVED that the House of Delegates endorse the continuance of this aforementioned program by acquainting the candidates for Governor of this resolution and urging their deliberate consideration of these facts.

Reference Committee No. 5 approves this resolution as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the resolution be adopted.

Resolution on Car Emblem for M.D.'s of the State of Kentucky

Mr. Speaker, we have a resolution concerning the appointment of a committee to select a distinctive medical car emblem for the M.D.'s of Kentucky in order that it might be more easily differentiated from those of other groups. This resolution follows:

RESOLVED, that a committee be appointed to select a distinctive medical car emblem for the M.D.'s of Kentucky in order that it might be more easily differentiated from those of other groups.

This Reference Committee approves this resolution and suggests to the committee to be appointed that the possibility of "MD." incorporated in license tags be investigated as a method of distinguishing physicians from other groups, and that this be on a voluntary basis.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the resolution be adopted.

Resolution on Medical Advertising

Mr. Speaker, we have a resolution on Medical advertising, which reads:

RESOLVED that the Executive Committee of the Boyd County Medical Society, acting for the Boyd County Medical Society, is of the opinion that the advertisement of the Holzer Hospital and Clinic of Gallipolis, Ohio appearing in the Classified Section of the Ashland, Kentucky telephone directory is not in accordance with standard medical ethics.

This Committee hereby requests the Committee on Medical Ethics of the KSMA to reiterate its policy and confirm or deny its policy in regard to this matter; and, further, that this opinion be disseminated to the Ohio Medical Association, the West Virginia State Medical Association, and such County Societies as are in the immediate vicinity of this Clinic.

Submitted herewith is the Ashland, Kentucky telephone directory with reference to the advertisement of the Holzer Clinic and Hospital on page 71, lower right hand corner.

Reference Committee No. 5 approves this resolution and recommends that it be referred to the Committee on Medical Ethics of the KSMA for study.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the resolution be adopted.

Resolution on Recommending Increase of Lunacy Fee Examination

Mr. Speaker, we have a resolution recommending an increase of lunacy fee examinations. The resolution follows:

WHEREAS, the cost of living has increased since 1930, and

WHEREAS, the fee a physician receives for examining a person to be committed to a mental institution has been and still is $3.00 and

WHEREAS, the fee is not commensurate

with the increase in cost of medical care;

BE IT THEREFORE RESOLVED, that the fee be increased to $10.00 since it requires an examination of the patient and a trip to the court house to sign the committment papers; and

BE IT FURTHER RESOLVED, that this resolution be presented to the proper committee of the legislature of Kentucky so that the laws pertaining to fees may be changed to that suggested in this resolution.

Reference Committee No. 5 has studied this resolution that the fee be increased from three to 10 dollars and approves this resolution, and that the resolution be presented to the proper committee of the legislature of Kentucky so that the laws pertaining to fees may be changed to that suggested in this resolution.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the resolution be adopted.

Resolution on Joint Commission on Accreditation of Hospitals

Mr. Speaker, we have a resolution concerning the Joint Commission on Accreditation of Hospitals, which follows:

WHEREAS, the individual and private practice of medicine has raised American medicine to its present high level envied by all nations;

WHEREAS, any system which deprives any physician, hospital, or groups of physicians or hospitals of their initiative will result in lowered standards of medical care;

WHEREAS, any organization, or groups of organizations which dictate standardization on a national level without adequate consideration of varying local problems, results in the deprivation of said initiative;

WHEREAS, the establishment of such standards to be met on a national scale, should only be arrived at, by the collective opinions of the individual hospitals and physicians involved;

WHEREAS, the present standards, as prescribed and enforced by the Joint Commission on Accreditation of Hospitals, have been arrived at by autocratic rather than by democratic methods;

WHEREAS, this autocratic system does not take into consideration the local, economic, and medical factors of each hospital which may be different, depending upon the type, size, degree of departmentalization, and financial resources, etc.;

WHEREAS, impractical standards for hospitals have already increased the cost of hospital care, and will continue to increase hospital costs, with no resulting benefit to the patient;

WHEREAS, the private practice of medicine is striving to lower hospital costs to patients and to increase voluntary prepaid hospitalization insurance at a premium which can be afforded by all income groups;

WHEREAS, requirements of the Joint Commission on Accreditation of Hospitals cause a definite increase in all hospitalization costs, by demanding unnecessary routine laboratory procedures and additional administrative costs;

WHEREAS, the medical profession is constantly being burdened by more and more rules and regulations;

WHEREAS, these various rules and regulations cause more and more time to be spent at various and sundry unnecessary meetings;

WHEREAS, these various meetings tend to separate the medical profession into various hospital groups to the detriment of the unity and strength of county and state medical societies, which are the backbone of American medicine;

WHEREAS, this disunity, increased cost of medical care, and possible breakdown of prepaid voluntary health insurance plans open the way to regimentation and governmental control of the practice of medicine;

WHEREAS, the inspections done in the past have frequently been made by personnel of the Joint Commission on Accreditation of Hospitals, unfamiliar with the private practice of medicine;

WHEREAS, the results of inspection have obviously been discriminatory in many respects;

WHEREAS, many of the criticisms offered by inspectors in individual instances have indicated obvious prejudice and lack of thorough understanding of the local situation;

WHEREAS, the Campbell-Kenton County Medical Society of Kentucky, feeling keenly its responsibility for the health needs of the people of our community and all communities and ever alert and anxious to institute and promote methods and practices which will better accomplish this purpose;

WHEREAS, the Campbell-Kenton County Medical Society of Kentucky strongly feels that the methods of the Joint Commission on Accreditation of Hospitals have failed to promote these ideals;

BE IT THEREFORE RESOLVED, that the KSMA go on record as vigorously opposing the present system, methods of operation and standards of the Joint Commission on Accreditation of Hospitals;

BE IT FURTHER RESOLVED that the delegates from Kentucky to the AMA present this resolution to the House of Delegates of the AMA at its next meeting and to work vigorously for its adoption;

AND FURTHER BE IT RESOLVED that copies of this resolution be sent to each of the members of the special committee appointed by the AMA to study the problems of the Joint Commission on Accreditation of Hospitals.

Reference Committee No. 5 carefully studied this resolution and approves it as submitted and suggests that the recommendations of this resolution be carried out.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that this resolution be adopted.

Resolution on Studying the Present Councilor Districts with Regard to a More Equitable Allocation of Councilors

Mr. Speaker, we have a resolution concerning the present councilor district set up which follows:

WHEREAS, the Council of the KSMA must represent all physicians in the state in their deliberations, and

WHEREAS, under the present councilor district proportionment a majority of the council members may represent a minority of the phy-

sicians in the state, and

WHEREAS, it is the desire and purpose of the Constitution and By-laws of the state association to provide for a council that will adequately reflect true and representative opinions on an equitable basis, therefore

BE IT RESOLVED, that the House of Delegates to the KSMA ask for a special committee to be appointed for the purpose of studying the present councilor districts regarding the selection of councilors on a more equitable population basis, and

BE IT FURTHER RESOLVED, that this committee be instructed to report their findings and recommend By-law changes to the House of Delegates at their meeting in 1956.

Reference Committee No. 5 approves this resolution and recommends that it be submitted to a special committee to be appointed for the purpose of studying the present council districts regarding the selection of councilors on a more equitable basis, and that this committee be instructed to report their findings and recommend By-law changes to the House of Delegates at their meeting in 1956.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the resolution be adopted.

Resolution on Opposition to the Policy of the Joint Commission on Hospital Accreditation Limiting the Number of Courtesy Staff Memberships in Private General Hospitals

Mr. Speaker, we have a resolution, on opposition to a policy of the Joint Commission on Accreditation of Hospitals, which follows:

WHEREAS, local traditions and usages have made good medical care often contingent on each physician having staff privileges in two or more hospitals, and

WHEREAS, pressure is currently being applied to the Joint Commission for Hospital Accreditation to cause local private hospitals to limit the number of physicians who may hold courtesy staff privileges, and

WHEREAS, this policy seems to connote a disregard of the patients choice in hospitals and create a community problem, therefore

BE IT RESOLVED, that the House of Delegates of the KSMA express opposition to the policy of the Joint Commission on Hospital Accreditation regarding the number of courtesy staff memberships in private general hospitals, and

BE IT FURTHER RESOLVED, that the Kentucky delegates to the AMA be instructed by this resolution to represent members of the KSMA as being opposed to this policy at the next meeting of the House of Delegates of the AMA.

The Committee approves this resolution as submitted.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the resolution be adopted.

Resolution on Discrimination Against Certain Groups of Doctors of Medicine by Exclusion of Such Groups from Membership on Hospital Staffs

Mr. Speaker, we have a resolution concerning discrimination shown certain groups of physicians of medicine by excluding them from membership on hospital staffs. The resolution follows:

WHEREAS, there have been instances reported in the State of Kentucky of exclusion by hospitals of certain groups of practicing physicians, Doctors of Medicine, engaging in one or other of the branches of medical practice, as a group, from membership on the hospital staff, and

WHEREAS, such exclusion directly limits and threatens some of the basic medical freedoms, such as freedom of the choice of physician, and

WHEREAS, such exclusion discriminates against the public welfare, by closing such hospitals to the patients of the excluded group of physicians, therefore,

BE IT RESOLVED, that the House of Delegates of the KSMA takes a clear stand as being opposed to the exclusion of any group or subdivision of licensed practicing physicians, as a group, from membership on the hospital staff of any hospital in Kentucky, whether such group be one of the recognized specialties or subspecialties of medicine, or composed of physicians in the general practice of medicine, and

BE IT FURTHER RESOLVED, that the KSMA is opposed to such exclusion either by restrictive clause or clauses in the constitution or by-laws of any such hospital, or by informal agreement of the governing board or staff of such hospitals with intent to accomplish such exclusion.

This resolution was carefully considered by your Reference Committee and your Reference Committee approves the resolution as submitted. The Committee does not believe that anyone should be excluded from hospital privileges that his training and capabilities would entitle him to regardless of his specialty or group that he belongs to. The committee interprets "certain groups of doctors" to pertain to general practitioners or specialists of any type.

Mr. Speaker, I move the adoption of this section of the report.

Motion was seconded and carried that the resolution be adopted.

Mr. Speaker, I move the adoption of this report as a whole.

Motion was seconded and carried that the report of Reference Committee No. 5 be adopted.

REFERENCE COMMITTEE NO. 5

Roy H. Moore, M.D., Louisville, Chairman
Glenn W. Bryant, M.D., Louisville
G. Y. Graves, M.D., Bowling Green
Carl Pigman, M.D., Whitesburg

At this time the following were elected to fill the vacant offices for the coming year:

President-elect .Richard R. Slucher, M.D., Buechel

Vice-presidents:

Central .....Everett H. Baker, M.D., Louisville

Eastern ..Nathaniel L. Bosworth, M.D., Lexington

Western .....Howell J. Davis, M.D., Owensboro

AMA Delegate...W. Vinson Pierce, M.D., Covington

Alternate AMA Delegate.....Leon Higdon, M.D., Paducah

At this time the delegates from the counties in the districts which were to elect councilors and who had held individual meetings after the first session of the House presented their nominations and the following councilors were elected:

Second District..Walter L. O'Nan, M.D., Henderson

Fifth District.....Carlisle Morse, M.D., Louisville
(to fill the unexpired term of Richard Slucher, M.D.)

Seventh District....Branham B. Baughman, M.D., Frankfort

Ninth District....J. M. Stevenson, M.D., Brooksville

Tenth District..J. Farra Van Meter, M.D., Lexington

Thirteenth District.....Charles B. Johnson, M.D., Russell

The Nominating Committee to serve at the 1955 Annual Meeting was elected as follows:

W. B. Atkinson, M.D., Campbellsville
Howell Davis, M.D., Owensboro
Tom J. Gilbert, M.D., Bowling Green
John S. Harter, M.D., Louisville
H. B. Stone, M.D., Hopkinsville

Recommendation of Members of K.S.M.A. for Membership on Board of Directors of the Kentucky Physicians Mutual, Inc.

The House of Delegates recommends that the following names be submitted to the Kentucky Physicians Mutual:

Branham B. Baughman, M.D., Frankfort
A. L. Cooper, M.D., Somerset
Mr. R. A. Dean
J. B. Lukins, M.D., Louisville
W. Vinson Pierce, M.D., Covington
Charles B. Stacy, M.D., Pineville
Bruce Underwood, M.D., Louisville
R. W. Robertson, M.D., Paducah
Warren Sergent, M.D., Lexington
John T. Bate, M.D., Louisville
Robertson Joplin, M.D., Louisville
W. K. Massie, M.D., Lexington

Mr. Speaker, I move that these names be submitted to the Kentucky Physicians Mutual, Inc.

Motion was seconded and carried.

The Speaker announced that he would appoint the Awards Committee at a later date.

There being no further business a motion was made, seconded and carried that the meeting adjourn at 12:00 P.M.

EDITORIALS

HERNIA IN INFANTS AND CHILDREN

Inguinal hernia in infants and children is almost always of the indirect type due to an unobliterated processus vaginalis leaving an opening between the peritoneal cavity and the inguinal canal. Many are complete with the sac going into the scrotum. These hernias frequently become incarcerated or strangulated when the infant coughs, cries, vomits or strains. Judging by their behavior these infants have considerable discomfort when intra-abdominal contents enter the canal and scrotum even when the hernia is still reducible. For many years the orthodox treatment was to wait for so-called spontaneous obliteration of the sac by the wearing of a truss usually the yarn type until the infant was a year or more old. Spontaneous obliteration rarely if ever ensued and frequent adjustment of the truss was troublesome for the mother with the danger of the above named complications always present. It was also thought that the delicate structures of the cord at an early age would be injured by operative handling and that was another reason for delaying operation. Subsequent experience has taught that this is not a valid objection as injury to the small structures can be avoided by careful gentle technic.

As the technical experience of surgeons increased with emergency operations for incarceration and strangulation, as anesthesiology improved, as after-care of the wound to avoid soiling from urine became better, surgeons, family physicians and pediatricians recognized that the best time for operative repair was when the hernia first appeared provided there were no positive contra-indications such as infection and malnutrition. Now we know that even though the baby be but a few weeks old the proper time for operation is as soon as possible after the diagnosis is made. The usual stay in the hospital is only 24 hours and the baby rarely misses more than one feeding.

Another advance in the treatment of hernia in infants and children is the recognition of the relationship of an obvious left inguinal hernia to an occult hernia upon the right. When a left inguinal hernia appears in a child under four years old, the chances of the child developing later a right inguinal hernia are so great that the surgeon is justified in operating upon the right side when the left side is repaired. In nearly all patients under four years old when the left side is repaired a definite hernial sac will be found upon the right if search is made for it. This fact was first brought to the attention of the medical profession by Orvar Swenson, M.D., of Boston before the American Academy of Pediatrics about two years ago.

In a personal communication, Dr. Swenson writes, "A number of older surgeons have known this fact about the relationship of bilateral hernias in regard to whether the lesion appears first as a right or a left sided hernia" but so far as he knows his was the first publication of the facts determined from a study of patients and records. So many other surgeons have corroborated Dr. Swenson's finding that now it is accepted practice to look for and repair a hernia upon the right when operating upon a left sided hernia in a young child. Many are consequently saved the hazard of a second hernia and the expense of the required hospitalization and operation.

MALCOLM THOMPSON, M. D.
BLAINE LEWIS, M. D.

Opinions expressed in contributions to this Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

THE ACUTE DUODENAL ULCER

Everything has a beginning—including duodenal ulcer. We are so accustomed to the theme that most ulcers are of long duration, five to seven years, when first seen, that we tend to lose sight of the acute phase of the disease. Yet, it is the new or acute ulcer which is most responsive to good therapy—most likely to heal permanently. Prophylactic measures against recurrence and chronicity are, at that phase, most effective.

The history and symptomatology of the acute ulcer are usually less clear-cut or classical than in its later, chronic phase. The hunger-pain and food-relief pattern is less clear. Night pain is less frequent. The rhythmic and periodic cycle of pain is not yet well established. The patient may complain only of a vague belly ache type of discomfort of a weeks duration or less. He may be in his teens, so young that we are not likely to even suspect ulcer. The physical and nervous stress which we so often associate with the disease may not be at all apparent.

Under such circumstances, we too often omit a careful history and examination. Some simple measures of temporary therapy are suggested, the symptoms improve or disappear and the patient is lost to further observation. He presents himself with the next recurrence to us or some other physician, too often for a repetition of the same procedure while his disease becomes more firmly established and the elements of chronicity appear.

When subjected to x-ray examination at this early phase, the demonstration of a distinct crater is often easy. Adequate treatment over a sufficient period of time is likely to result in complete healing of the lesion. The patient, aware of the disease, is very receptive to advice regarding diet, medication, habits of living and work, that may spare him an endless series of recurrences, chronicity and complications. Our best services in the treatment of ulcer are often lost because we fail to carry our investigations to a definite diagnosis in the very early phase of the disease.

The complications of acute ulcer are hemorrhage and perforation. Especially during the war, when so many young men were displaced from their normal environment and pursuits, it was not at all unusual to be confronted with a massive hemorrhage or a perforation in a service man twenty years old or younger. Nor have such occurrences been rare since then. These complications may seem to occur out of a clear sky without preceding symptoms. Careful questioning, however, will almost always reveal that at least a short period of digestive disturbance has preceded the dramatic event.

The perforation should, in our opinion, be treated surgically—rarely so the massive hemorrhage. As in the case of simple ulcer, the results of treatment, medical or surgical, following these complications offers a very good prognosis. There is a growing belief that when perforation occurs, immediate gastric resection is a treatment of choice since it will better assure permanent cure without recurrence. This course would certainly seem inappropriate in the case of an acute ulcer, especially in a young individual, since with good medical care prognosis is particularly good.

The acute ulcer is an interesting phase of the disease and deserves special attention. We may well regard it as the most important period—the time when intelligent care, guidance and prophylaxis may spare recurrent grief and disability in succeeding years.

SAM A. OVERSTREET, M. D.

ORGANIZATION SECTION

Nationally Known MD's to Speak at Officers Conference March 29, Lexington

Nationally known medical leaders from both coasts will be featured at the sixth annual county Society Officers Conference to be held in Lexington, Thursday, March 29, at the Phoenix Hotel.

Among the speakers who will participate in the meeting are: Dwight Murray, M.D., Napa, California; Mr. William L. McGrath, Cincinnati, Ohio; and David Allman, M.D., Atlantic City, New Jersey.



Dr. Murray

Dr. Murray, a 1917 graduate of the Indiana University School of Medicine, is the President-Elect of the American Medical Association. Long active in AMA affairs he is the immediate past chairman of the Board of Trustees. Dr. Murray is a general practitioner.

Mr. Mc Grath, a native of Ohio, is in great demand by medical groups throughout the country. He is the employer's representative to International Labor Organization. President of a heating firm in Cincinnati, he is director of a trust company, gas and electric company, newspaper, tile manufacturing company and the National Association of Manufacturers.



Mr. McGrath

Dr. Allman is a 1914 graduate of the Jefferson Medical College in Philadelphia. He is chairman of the AMA Legislative Committee and a member of the Board of Trustees. Dr. Allman is a surgeon.

Gant Gaither, M.D., KSMA President, said that as the purpose of the conference was to strengthen the organization of local county medical societies, and to build a more effective public service program, he felt county and state medical society officers would find it a most profitable meeting.

The February issue of the Journal will carry complete details of the program.

Complacency is Greatest Enemy Dr. Hess Tells Physicians

Complacency is the greatest enemy of the medical profession, Elmer Hess, M.D., Erie, Pa., President of the AMA, told physicians at the 9th Annual Clinical Meeting in Boston Nov. 29-Dec. 2.

Dr. Hess, in a mid-year report to the House of Delegates, reminded the group that with today's problems and differences of opinions between hospitals and radiologists, pathologists and anesthesiologists, never to forget that the patient's welfare comes before anything else.

He thanked the Joint Commission on Accreditation of Hospitals saying that the citizens of this country, hospitals and physicians owed much to this commission for the service it has rendered.

Some other features of the Clinical Meeting were an "Atoms for Peace" report, a concert by the Boston Symphony, a clinic on poliomyelitis, and discussions on adolescent medicine and heart disease.

RH Meeting, Jan. 19, to Feature Discussions, Dramatic Skit

"Do It Now With What You Have" is the theme of the 1956 Rural Health Conference to be held Thursday, January 19 at the Kentucky Hotel in Louisville. Registration will be held at 9:00 a.m., and the meeting will adjourn at 3:55 p.m.

Gant Gaither, M.D., President of the KSMA, urged all Kentucky physicians living in rural areas to attend the meeting and bring with them leaders from their communities interested in the betterment of rural health.

Leonard E. Read, President of the Foundation for Economic Education, will be the principal luncheon speaker. A panel of distinguished heart specialists will discuss "Your Heart."

Other program features will be a discussion entitled "Using Our Present Medical Care and Health Resources." A farmer, a 4-H girl, an FFA boy, a physician, a home demonstration agent and a mother will participate in this discussion. The Kentucky Farm Press and Radio Association will present a dramatic skit.

"Every Kentuckian is invited to attend the

meeting," said Wyatt Norvell, M.D., Chairman of the Kentucky Rural Health Council, "but especially do we urge all persons who have special interest in matters affecting Kentucky Rural Health to attend."

Presiding officers at the conference, which is sponsored by the Kentucky Rural Health Council, will be: Frank J. Welch, PhD., Dean of the UK College of Agriculture and Home Economics; Burl S. St. Clair, President of the Kentucky Farm Bureau Federation; and Dr. Norvell.

Pennsylvania Physician Named AMA's GP of the Year

E. Roger Samuel, M.D., Mt. Carmel, Pa., "a typical American family doctor," was named the General Practitioner of the year at the opening session of the AMA House of Delegates.

Dr. Samuel, 66, has been a general practitioner for 35 years. He is active in charitable, civic and medical organization work. He was chosen by an unidentified AMA committee from candidates nominated by state medical associations.

Joseph I. Greenwell, M.D., retired New Haven physician, was the recipient of the AMA's 1954 citation.

Two Specialty Groups Added to 1956 Annual Meeting

Plans to include two new groups in the Specialty Group Sessions at the 1956 Annual Meeting, September 18-20, were discussed at the meeting of the Committee on Scientific Assembly Nov. 17, at the Brown Hotel in Louisville.

These two, the Radiology Group and the Orthopedic Society, will hold simultaneous meetings with the nine other specialty groups Wednesday afternoon, September 19. The meeting places will be the same as in 1955—First Christian Church and the Episcopal Church.

Gant Gaither, M.D., Chairman of the Committee, announced the '56 Annual Meeting would be held in Columbia Auditorium. He said color television would not be available for the meeting, but that there would be two hours of scientific movies each morning.

The nine specialty groups besides the above mentioned two are: Kentucky Society of Anesthesiologists; Kentucky Chapter, American College of Chest Physicians; Kentucky Eye, Ear, Nose and Throat Society; Kentucky Chapter, American Academy of General Practice; Kentucky Obstetrical and Gynecologic Society; Kentucky Chapter, American Academy of Pediatrics; Kentucky Chapter, American College of Physicians; Kentucky Psychiatric Association; and American College of Surgeons.

11 Kentucky Surgeons Inducted As New Fellows of ACS

Eleven Kentucky physicians were inducted as fellows of the American College of Surgeons at the cap-and-gown ceremonies at the close of the ACS Clinical Congress in Chicago, November 5.

The inductees were: Drs. Kurt Ackerman, David W. Griffin, Oscar J. Hayes, and Harold E. Kleinert of Louisville; James K. Conlan, Harlan; Ernest A. Golia, Jenkins; T. Rothrock Miller and Kearns R. Thompson, Jr. of Lexington; George H. Widener, Paducah; Russell H. Davis, Pikeville and Maj. Ralph G. Thomas, Leitchfield.

Fellowship in the ACS, which was founded in 1913, is based on advanced training in surgery and "evidence of good moral character and ethical practice."

Post-Graduate Medical Education Discussed by Committee

Long range plans for an effective program of post graduate medical education for Kentucky's physicians were discussed in detail on December 1 in Louisville at a meeting of the KSMA Committee on Medical Education.

Proposed plans, according to Garnett Sweeney, M.D., Liberty, chairman of the committee, call for the organization of the program by the KSMA with the active support of the University of Louisville and the Kentucky Chapter of the American Academy of General Practice.

Tentative agreement provides for the development of a trial operation of the plan in a given locality. The plan is based somewhat on the "Kansas Plan." The University will furnish the program and the medical groups will stage and promote it.

"The enthusiasm, the unanimity of opinion, and the desire on the part of all present at the meeting to develop a workable, effective post graduate program, one that will carry into every section and be within reach of every KSMA member, was most heartening," Dr. Sweeney said. It was pointed out that the plans will take time for development, but it

was felt with patience and continued cooperation, the program will become highly successful.

Participating in the planning were Charles G. Bryant, M. D., Louisville, Chairman of the Kentucky Chapter of the American Academy of General Practice and Howe Eller, M. D., Louisville, Director of postgraduate refresher training at the University of Louisville School of Medicine.

Other members of the Committee on Medical Education are: Harry Andrews, M. D., Louisville; Herbert Clay, M. D., Louisville; Allen Cornish, M. D., Lexington; Joseph Hamilton, M. D., Louisville; Robert Lich, Jr., M. D., Louisville; John C. Quertermous, M. D., Murray; and Leslie H. Winans, M. D., Ashland.

Dr. Pierce Re-elected President of Blue Shield Organization

W. Vinson Pierce, M. D., Covington, has been re-elected president of the Kentucky Physicians Mutual Inc., the Blue Shield Medical Care plan. Newly elected first and second vice presidents are Coleman C. Johnston, M.D., Lexington and William H. Cartmell, M. D., Maysville, respectively.

Re-elected were Branham B. Baughman, M. D., Frankfort, treasurer; Raymond F. Dixon, Louisville, secretary and assistant treasurer; D. Lane Tynes, Louisville, executive director.

Stanley Simmons, Louisville, was re-elected medical consultant and W. K. Massie, Jr., Frankfort, was chosen a new director of the group.



J. Duffy Hancock, M.D., representing Blue Cross-Blue Shield, presents a picture, "Skilled Hands" to J. Murray Kinsman, M.D., Dean of the University of Louisville School of Medicine. The picture will be hung in the annex to the Amphitheater of General Hospital.

HR 7225, OASI Are Big Topics As AMA's Delegates Meet

HR 7225, OASI, Coverage of Physicians, Report on Medical Practices, Guides for Grievance Committees, and Medical Ethics were the main topics of discussion by the AMA House of Delegates at the 9th Clinical Meeting in Boston, Nov. 29-Dec. 2.

The following actions were taken:

HR 7225: The House voted to urge and support the creation of a commission to study the economic, social and political impact of Social Security, and that the facts got from the study be a basis for objective non-political improvements to the Social Security Act.

OASI Coverage of Physicians: The House recommended that State Societies poll their members on the inclusion of physicians in the Old Age and Survivors Insurance provision of the Social Security Act and send the results of the poll to the AMA office immediately.

Report of Medical Practices: The House voted to implement the findings and recommendations of the Committee on Medical Practices, which studied the basic causes leading to certain unethical practices and unfavorable publicity. One of the points included in the resolution was: "The Continuing Committee on Medical Practice be created to conduct a study of the value of diagnostic, medical and surgical service and to report its findings to the House."

Guides for Grievance Committees: The House approved the report of the Committee to Recommend Guides for Grievance or Mediation Committees.

The Reference Committee on Miscellaneous Business made the following recommendations which were adopted by the House.

"Your reference committee desires to support the recommendation that a brochure be published promptly which will outline the recommendations regarding the activities of Grievance Committees and that this brochure be given wide distribution."

The purpose of the guides is "to promote general uniformity of organization and function of grievance committees—and better understanding of their purposes—without interferring with the inherent autonomy of constituent medical associations."

Medical Ethics: A proposed revision of the "Principles of Medical Ethics and Precepts of Manners of the AMA," was submitted to the House by the Council on Constitution and Bylaws. The House approved a plan requiring that all changes be considered over a period between sessions of the House before final adoption.

The House of Delegates performed the following miscellaneous actions. 1. Recommended that the Board of Trustees give consideration to an increase in dues for AMA members. 2. Adopted a resolution on the practice of pathology declaring opposition to "the division of any branch of medical practice into so-called technical and professional services." 3. Recommended that further purchase and distribution of Salk polio vaccine be carried on by the presently available commercial avenues used for other immunizing agents, and that all vaccines, once proven, should enter the usual channels of distribution. 4. Approved a recommendation that the SJAB be separated from the AMA. 5. Approved Minneapolis as the location for the 1958 Clinical Meeting and Chicago for the 1960 Annual Meeting.

13 Kentucky Physicians Attend Clinical Meeting in Boston

Both of KSMA's delegates to the AMA, Clark Bailey, M. D., Harlan and Bruce Underwood, M. D., Louisville, were present at the AMA's 1955 meeting of the House of Delegates at the Clinical Meeting in Boston, Nov. 29-Dec.2.

According to the AMA Daily Bulletin, other Kentucky, physicians who attended the meeting were: Mary C. Long, M. D., and Edward Warrick, Jr., M. D., Louisville; Paul A. Bryan, M. D., and John Pepper, M. D., Ashland; W. Vinson Pierce, M. D., and R. H. Cofield, M. D.; Covington.

G. Y. Graves, M. D., Bowling Green; Merle M. Mahr, M. D., Madisonville; Herbert White, M. D., Lexington; David McL. Greeley, M. D., Harlan; Charles L. Roach, M. D., Lackey.

Gant Gaither, M.D., Announces Senior Day Committee

Gant Gaither, M. D., Hopkinsville, President of the KSMA, has appointed the committee to set up the program for the second annual Senior Day to be held in Louisville April 16. The purpose of the Senior Day program is to help bridge the gap between academic medicine and the practice of medicine.

Richard Elliott, M. D., Lexington, has been named chairman of the committee. Dr. Elliott is chairman of the KSMA Committee on Public Information and Service.

Other members of the committee are. Irvin Abell, M. D., Louisville, 1956 President of the Jefferson County Medical Society; W. O. Johnson, M. D., Louisville, KSMA Representative to the Student AMA Council (U of L Chapter); J. Murray Kinsman, M.D., Louisville, Dean, University of Louisville Medical School; and Karl Winter, M. D., Louisville, Chairman of the KSMA Medical School Advisory Committee.

54 Kentucky Physicians Attend SMA Meeting in Houston

Fifty four Kentucky physicians attended the 59th Session of the Southern Medical Association Annual Meeting November 14-17 in Houston, Texas.

Clayton McCarty, M. D., Louisville, KSMA's councilor to SMA, and newly elected Vice Chairman to the Council, acted as moderator of a Geriatrics Symposium. The symposium, a new feature of the annual meeting, was held in the Shamrock Hotel.

Two Kentucky physicians were named section officers for 1956. They are: Jesshill Love, M. D., Louisville, Radiology and Robert Monroe, M. D., Louisville, Obstetrics.

According to the SMA Daily Bulletin the following Kentucky physicians attended the meeting:

George Sanders Benton, William A. Johnson, Rex O. Morris, Gradie Rowntree, Marjorie Rowntree, R. J. Alberhasky, Ed T. Arnn, L. Douglas Atherton, John P. Bell, Wesley G. Farnsley, Louis M. Foltz, William Hagan, John S. Harter, Douglas M. Haynes, J. Kenneth Hutcherson, Robert Lich, Jesshill Love, Marvin A. Lucas, Arthur Clayton McCarty, Oscar O. Miller, Robert F. Monroe, William Ray Moore, Charles T. Moran, Carlisle Morse, Paul S. Osborne, Sam A. Overstreet, George H. Ray, Henry G. Saam, Carroll L. Witten, Oscar Block, Lawrence A. Davis, Ray Remmers, and Parnell Rollings, all of Louisville.

Howell Davis, O. Harlan Wilson, Owensboro; M. M. Hall, Layman S. Hall, Campbellsville; Rex Hayes, Glasgow; C. M. Heisel, William R. Miner, A. J. Schwertman, Covington; Ralph Lynn, Elkton; Ora Mason, Murray; R. D. Sanders, Williamsburg; David Jones, Fulton; A. D. Steely, Bardstown; Douglas E. Scott, Jack Webb, Carl M. Friesen, William Massie, Franklin Moosnick, Lexington; M. C. Spradlin, Somerset; D. L. Vaughn, Henderson; and Nelson Widmer, Lebanon.

Glasgow MD Named President of Sixth District Group

Russell Starr, M. D., Glasgow, was elected president of the Sixth Councilor District at a meeting in Franklin Nov. 8. Dr. Starr succeeds Frank Moore, M. D., Bowling Green.

Lillard Beasly, M. D., Franklin, was elected vice president and Harold Keen, M. D., Bowling Green, was re-elected treasurer of the society. L. O. Toomey, M. D., Bowling Green, is the councilor from the Sixth District.

Barton McSwain, M. D., Nashville, Tennessee, and Robert McKinley, M. D., Glasgow, presented the scientific program for the evening. Dr. McSwain discussed, "Carcinomas of the Colon and Rectum" and Dr. McKinley gave a talk on "Practical Application of Intravenous Therapy."

Dr. Rust, Newport, Is Chairman of New KSMA Committee

Richard Rust, M. D., Newport, has been named chairman of the KSMA Committee to Study Committee and Organizational Structure. The appointment was made by Charles Vance, M. D., Lexington, speaker of the House of Delegates.

The committee was formed as a result of the adoption of a recommendation made by Clyde C. Sparks, M. D., Ashland, 1955 KSMA president, in his President's Address at the '55 Annual Meeting. The recommendation stated: "A special committee of this House be appointed to study our committee, and any other organizational structure problem it may consider proper and report at the 1956 annual session."

Other members of the Committee appointed by Dr. Vance are: E. H. Baker, M. D., Louisville; Ward Bushart, M. D., Fulton; Cooley Combs, M. D., Hazard; Richard G. Elliott, M. D., Lexington; Joseph Kurre, M.D., Owensboro; Wyatt Norvell, M. D., New Castle; Robert Robertson, M. D., Paducah, Clyde C. Sparks, M. D., Ashland; and Ernest C. Strode, M. D., Lexington.

UMW Hospital in Middlesboro Opened in Late November

The first of the chain of ten hospitals built by the Miners Hospital Association for beneficiaries of the UMW Welfare and Retirement Fund, opened at Middlesboro late in November. Ky. Miners Memorial Hospital is the name given the new hospital with a capacity of 80 beds and 16 bassinets.

Other hospitals being built by the association in Kentucky will vary in size from 50 to 200 beds and will be in operation in Harlan, Hazard, Pikeville, McDowell, and Whitesburg.

One of the newest institutions will be built in Wise, Virginia. West Virginia will have three—at Williamson, Man, and Beckley.

October Conference Postponed, Re-scheduled for Spring

The fourth conference on Medical Care in the Bituminous Coal Mine Area which had been scheduled for October 1, at Charleston, W. Va., will be held next spring. The October Conference was postponed because of the death of Carl M. Peterson, M. D., Secretary of the AMA's Council on Industrial Health.

The five state conference is sponsored by the Committee on Medical Care for Industrial Workers of the AMA. Clark Bailey, M. D., Harlan, is a member of the committee.

States included in the five states are Tennessee, Kentucky, Virginia, West Virginia and Pennsylvania.

Cardiovascular Disease Symposium Scheduled For January 20

The second annual Symposium on Cardiovascular Diseases, will be held January 20, 1956 in the Louisville General Hospital Amphitheatre. The meeting is sponsored by the Louisville Heart Association, Inc.

Featured on the program will be a panel discussion. "Long Term Management of Coronary Artery Disease," and two guest lecturers, Irving S. Wright, M. D., New York City, and Julian Johnson, M. D., Philadelphia.

According to John H. Llewellyn, M. D., president of the association, the symposium is open to physicians, interns, residents, medical students, nurses, technicians and other hospital personnel.

Downtown Hospital Site Favored According to Physician Poll

A poll of the Jefferson County Medical Society November 21 revealed that its members favored building a new Methodist Evangelical Hospital on the Louisville Medical Center location rather than on the Claggett estate at Emerson and Dundee.

Six hundred post card questionnaires were sent to the society members. Of this number, 456 (76%) were returned. The result of the poll according to Harry Lehman, Executive Secretary of the Jefferson County Medical Society, was: For the Medical Center, 225; for the Claggett Estate, 206; no preference, 25.

Of the twenty five physicians who showed no preference it was stated many felt that the site of the proposed hospital was not the concern of the Jefferson County Medical Society.

Guy Aud, M.D., Honored by ACS

Guy Aud, M.D., Louisville, past president of the KSMA, has been elected an Honorary Life Member of the Board of Directors of the American Cancer Society. Dr. Aud is a former director and president of the Society.

Other Honorary members are: General William J. Donovan; Eric A. Johnston, C. C. Nesselrode, M.D., Mrs. Anna M. Rosenberg; Alfred P. Sloan, Jr.; and James V. Stuart.

MD's Have New Member Dinner

Forty six physicians attended the Jefferson County Medical Society's New Member Indoctrination Dinner Dec. 1, at the Big Springs Golf Club in Louisville. The dinner was sponsored by the Public Relations Committee.

According to Stanley Simmons, M.D., Louisville, Chairman of the Public Relations Committee, the following persons participated in a panel discussion moderated by Carroll Witten, M.D., Louisville; Gradie R. Rowntree, M.D., President; Harry A. Lehman, Executive Secretary; Carlisle Morse, M.D., State Councilor; J. Randolph Buskirk, M.D., Member of the Public Relations Committee; Dr. Simmons; and Robert Clarke, feature writer of the Louisville Courier Journal.

50 MD's Attend Muldraugh Meet

Approximately 50 physicians attended the Muldraugh Hill Medical Society Meeting at St. Anthony's Hospital in Louisville, Dec. 8, according to Joseph C. Ray, M.D., Louisville, secretary of the society.

The following physicians participated in the program: Lanier Lukins, M.D., P. M. Crawford, M.D., Pat Cummings, M.D., A. M. Isaacs, M.D., Joseph Armstrong, M.D., Lester Reed, M.D., Gordon Smiley, M.D., John M. English, M. D., all of Louisville; Capt. Murrey E. Finn, MC., Fort Knox; R. Burke Casper, M.D., Brandenburg; and Maj. Albert J. Davis, Jr., M. C.

Educators Congress Planned in Feb.

More than 500 medical educators, officers and members of state licensing boards are expected to attend the 52nd Annual Congress on Medical Education and Licensure which will be held February 11-14 at the Palmer House in Chicago.

Saturday's program,(Feb. 11), will give special attention to current problems in residency; and Monday's program (Feb. 13) will deal with trends in specialization, problems relating to clinical faculty appointments and the private practice of medicine, and new approaches in medical education.

Dr. Quill Heads RR Surgeons

Laurence M. Quill, M.D., Newport physician, has been elected President of the Association of Surgeons of the Chesapeake and Ohio Railroad.

A native of Ohio, Dr. Quill is a '35 graduate of the University of Cincinnati College of Medicine.

GP's to Meet March 19-22

The eighth annual American Academy of General Practice Scientific Assembly will be held March 19-22 in the Washington D. C. Armory.

Twenty six speakers will participate in the four day scientific meeting, and Surgeon General Leonard Scheele will deliver an address to the group. Other attractions will be 60 scientific and 250 technical exhibits. Two live clinics, a symposium on obstetrics and special tours through the National Institutes of Health, Bethesda, Md. are on the agenda.

Health Congress Begins Jan. 23

Elmer Hess, M.D., President of the AMA, and Benson Ford, Vice President of the Ford Motor Company, will be the principal speakers at the 16th Annual Congress on Industrial Health Jan. 23-24 at the Sheraton-Cadillac Hotel in Detroit.

The Congress is sponsored by the Council on Industrial Health, AMA; Wayne County Medical Society; Michigan State Medical Society; Michigan Industrial Medical Association; Detroit Industrial Physician's Club; and the Detroit Society for Surgery of Trauma.

WA Members Attend CD Meeting

Mrs. R. Ward Bushart, Fulton, President of the Woman's Auxiliary to the KSMA, and Mrs. J. A. Outland, Murray, member of the Civil Defense Committee of the WA, participated in the Nov. 15 meeting of Civil Defense for Kentucky Women at the University of Kentucky. They took part in the program on Home Nursing.

A paper entitled "Radioactive Fallout and Its Problems" was presented by Theodore L. Adams, M.D., chairman of the KSMA Emergency Medical Service Committee.

Hagan Fund to go to Collins Field

A memorial fund in honor of the late James E. Hagan, M.D., Hazard, has been turned over, by his wife, to the improvement program at Collins (Athletic) Field in Hazard. Dr. Hagan died October 23, 1955.

The $300 fund is the result of contributions by friends of Dr. Hagan, following his death, when his wife asked that any tribute to her husband be in the form of pledges which could be given to a worthy cause.

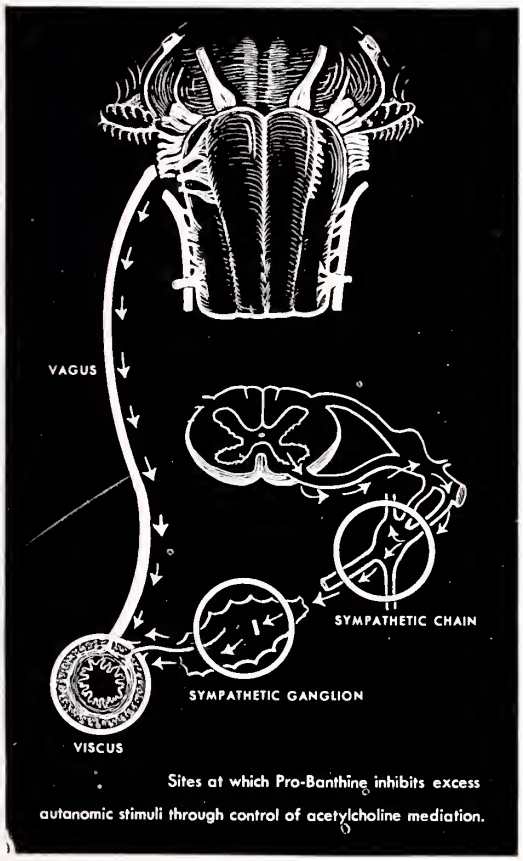
PRO-BANTHĪNE® FOR ANTICHOLINERGIC ACTION

A Combined Neuro-Effector and Ganglion Inhibitor

Pro-Banthīne consistently controls gastrointestinal hypermotility and spasm and the attendant symptoms.

Pro-Banthine is an improved anticholinergic compound. Its unique pharmacologic properties are a decided advance in the control of the most common symptoms of smooth muscle spasm in all segments of the gastrointestinal tract.

By controlling excess motility of the gastrointestinal tract, Pro-Banthine has found wide use[1] in the treatment of peptic ulcer, functional diarrheas, regional enteritis and ulcerative colitis. It is also valuable in the treatment of pylorospasm and spasm of the sphincter of Oddi.



Sites at which Pro-Banthine inhibits excess autonomic stimuli through control of acetylcholine mediation.

Roback and Beal[2] found that Pro-Banthine orally was an "inhibitor of spontaneous and histamine-stimulated gastric secretion" which "resulted in marked and prolonged inhibition of the motility of the stomach, jejunum, and colon. . . ."

Therapy with Pro-Banthine is remarkably free from reactions associated with parasympathetic inhibition. Dryness of the mouth and blurred vision are much less common with Pro-Banthine than with other potent anticholinergic agents.

In Roback and Beal's[2] series "Side effects were almost entirely absent in single doses of 30 or 40 mg. . . ."

Pro-Banthine (β-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is available in three dosage forms: sugar-coated tablets of 15 mg.; sugar-coated tablets of 15 mg. of Pro-Banthine with 15 mg. of phenobarbital, for use when anxiety and tension are complicating factors; ampuls of 30 mg., for more rapid effects and in instances when oral medication is impractical or impossible.

For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.

---

1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.

2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

Clinical trial packages of Pro-Banthīne and the new booklet, "Case Histories of Anticholinergic Action," are available on request to . . .

SEARLE

P. O. Box 5110-B-13
Chicago 80, Illinois

Radiologists Develop TB Program

A new five point program aimed at guiding mass chest x-rays screening programs for the detection of pulmonary tuberculosis has been announced by the American College of Radiology. This Association is composed of physicians who specialize in the use of x-rays, radium and other radioactive substances for diagnosis and treatment of disease.

Three of the points brought out by the association in their program are: (1.) Prior arrangements for prompt follow-up medical examination and definitive diagnosis of all persons reported to have abnormal pulmonary x-ray shadows. (2.) Prior arrangements for adequate medical care and hospitalization of all persons found as a result of the survey to be in need of such. (3.) Prior arrangements for adequacy of roentgen examination and interpretation.

Atlanta Meet Begins February 20

The annual meeting of the Atlanta Graduate Medical Assembly will be held at the Atlanta Biltmore Hotel, February 20-22, 1956. Top specialists in all fields of medicine will participate in the meeting, according to Mark Dougherty, M D., chairman of the Publicity Committee.

New KSMA Members

Thirteen new members have been added to the KSMA membership roster. They are:

Harry James Batts, M.D., Louisville
Lotte Bernstein, M.D., Louisville
Clarence K. Dixon, M.D., Louisville
Harvey C. Hardegree, M.D., Louisville
Douglas M. Haynes, M.D., Louisville
Rebecca H. Hechter, M.D., Louisville
Rex R. Johnson, M.D., Owenton
G. George Maier, M.D., Louisville
Ernest R. Seitz, M.D., Louisville
William W. Spalding, M.D., Louisville
John L. Vogel, M.D., Louisville
Jay W. Wilson, M. D., Jeffersontown
John L. Wolford, M.D., Louisville

Former surgeon general of the Navy, Ross T. McIntire, M.D., recently wrote in the Journal of the International College of Surgeons that in an atomic or guided missile war, blood and its derivatives will be the surgeon's greatest aids.

THE CINCINNATI SANITARIUM

FOUNDED IN 1873



One of the oldest private hospitals in the United States operated for the care and treatment of nervous and mental patients.

Modernly equipped to provide the use of all accepted methods of treatment. Constant medical supervision with registered nurses in charge. Ample classification facilities.

Conveniently located, twenty nine acres of beautiful grounds assure complete privacy.

MEMBER OF: American Hospital Association, Ohio Hospital Association, Central Psychiatric Hospital Assoc.

APPROVED BY: American College of Surgeons, Council of Hospitals.

LICENSED BY State of Ohio.

D. A. JOHNSTON, M.D. ... *Medical Director*
W. N. WRIGHT, M.D. *Resident Psychiatrist*
HENRY GRUENER, M.D. *Resident Physician*
ELLIOTT OTTE ..... *Business Administrator*

Rest Cottage, beautifully furnished, is a separate department devoted to the care of certain psycho-neuroses, rest, and convalescent cases.



Write for descriptive booklet
THE CINCINNATI SANITARIUM
3642 Hamilton Avenue Cincinnati 24, Ohio
Telephones: Kirby 0135, Kirby 0136



...in antibiotic therapy are revealed by current reports on

Tetracyn®

BRAND OF TETRACYCLINE

– Pfizer-discovered tetracycline

Tetracycline is notable among broad-spectrum antibiotics for its solubility and stability. And, clinical trials have established that tetracycline is an efficient antibiotic against those diseases due to susceptible microorganisms.

Tetracyn is available in a variety of oral, parenteral and topical dosage forms for the treatment of a wide range of susceptible infections.

Pfizer

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, N.Y.

SOCIAL SECURITY—BIG ISSUE IN '56

(Continued from page 55)

of this developing program, because we do not believe that either the Congress or the public has any conception of its magnitude."

Our social security system now has reached the point where any further changes may have a profound influence on the nation's economic, social and political future. The time has come to face up to the question of just what social security should accomplish and just where it should stop. The Association strongly urges that the social security issue be taken out of the arena of vote-catching politics; that there be an objective, thorough study of social security in all its present and future aspects, and that the facts and realities emerging from such a study be used as the basis for a sound national decision on this vital issue. It especially protests precipitate action on the complex question of disability without thorough investigation of alternative mechanisms.

In our opinion, that is a reasonable, responsible policy that deserves the moral and intellectual support of every physician.

News Items

Charles Fisher, M.D., a 1953 graduate of the University of Louisville School of Medicine, has begun practice in Madisonville. Dr. Fisher, who interned at General Hospital in Louisville, recently moved to Madisonville from Flemingsburg.

A. Stark Walkoff, M.D., has recently opened offices in Louisville for the practice of obstetrics and gynecology. Dr. Walkoff, a '50 graduate of the Hahnemann Medical College in Philadelphia, interned at Philadelphia General Hospital. He served residencies at the Hahnemann Hospital in Philadelphia and the Louisville General Hospital.

Samuel Scheen, M.D., formerly of Cloverport, is taking a residency in dermatology at the General Hospital in Cincinnati. Dr. Scheen is a '53 graduate of the University of Louisville School of Medicine. He took his internship at the St. Joseph Hospital in Louisville.

Jerry McKenney, M.D., '54 graduate of the University of Louisville School of Medicine, has moved from Lexington to Marion in Crittenden County. Dr. McKenney recently completed his internship at the Good Samaritan Hospital in Lexington.

THE NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL (Organized 1881)
(The Pioneer Postgraduate Medical Institution in America)

EYE, EAR, NOSE and THROAT

A three months combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstrations of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology, bacteriology and embryology; physiology; neuro-anatomy; anesthesiology; physical medicine; allergy, as applied to clinical practice. Examination of patients preoperatively and follow-up postoperatively in the wards and clinics. Attendance at departmental and general conferences.

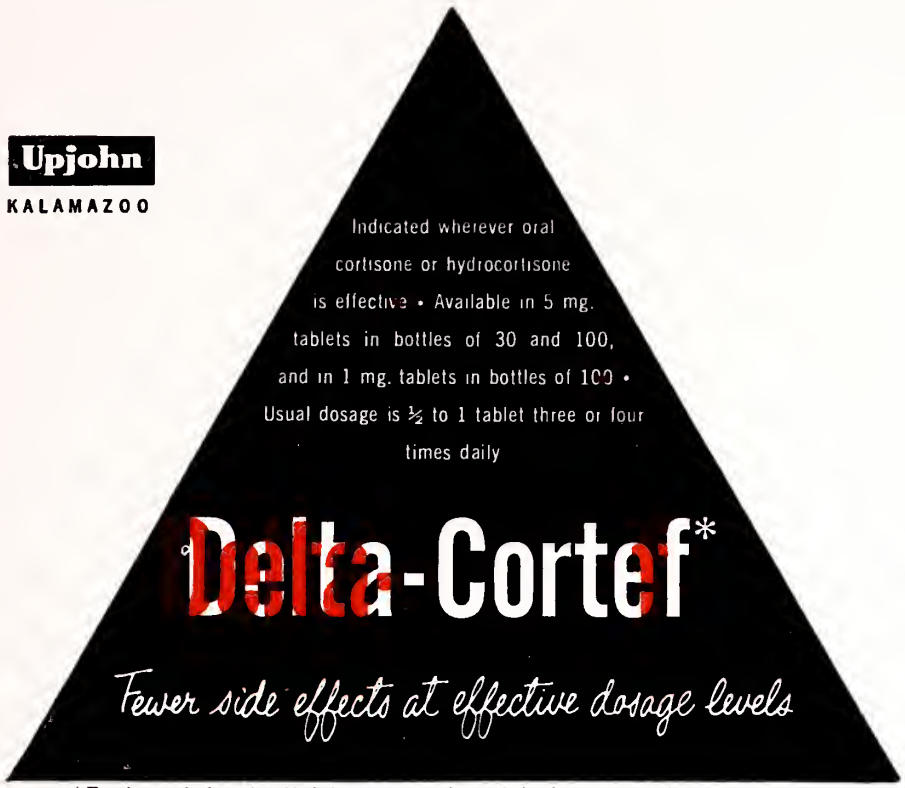
PRACTICAL ELECTROCARDIOGRAPHY

A two weeks part time elementary course for the practitioner based upon an understanding of electrophysiologic principles. Standard, unipolar and precordial electrocardiography of the normal heart. Bundle branch block, ventricular hypertrophy, and myocardial infarction considered from clinical as well as electrocardiographic viewpoints. Diagnosis of arrhythmias of clinical significance will be emphasized. Attendance at, and participation in, sessions of actual reading of routine hospital electrocardiograms.

For Information about these and other courses Address THE DEAN, 345 WEST 50th St., New York 19, N. Y.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.



*Trademark for the Upjohn brand of prednisolone (delta-1-hydrocortisone)

Pertinent Paragraphs

Two speech therapists and a student occupational therapist have been granted scholarships by the National Society for Crippled Children and Adults and Kappa Delta Phi, national sorority. The grants are in support of two different projects co-sponsored by the two groups: the Speech Correction Fund program and a project which assists occupational and physical therapy students to finish their training. Funds recently appropriated by the sorority will continue the scholarship program during the coming year.

The American College of Surgeons will hold a four day Sectional Meeting in Philadelphia, Pa., February 13-16. Sessions in general surgery and the specialties, hospital clinics, surgical Forum research reports, cine clinic films, technical exhibits, and hospital field trips will be included in the program.

Four oral and four written examinations for Fellows in the United States Section of the International College of Surgeons will be conducted in 1956. Oral conferences will be held on January 23, April 16, August 6, and October 22. The written examinations will be held on January 30-31, April 23-24, July 23-24 and October 29-30. Both the oral and written examinations will be given at the Cook County Hospital and Cook County Graduate School of Medicine, Chicago.

Physicians and their wives are invited to attend the sectional meeting of the International College of Surgeons to be held at the Greenbrier Hotel at White Sulphur Springs, West Virginia, February 12-15, 1956.

The Fourth Postgraduate Course on Diabetes and Basic Metabolic Problems sponsored by the ADA, will be given at the new Statler Hilton Hotel in Dallas, Texas, Jan. 25-26-27. The course, open to members of the medical profession, is $40 for ADA members and $75 for nonmembers.

The 1955 Annual Meeting of the American Academy of Allergy will be held February 6-8 at the Chase Hotel in St. Louis, Missouri. There is no registration fee for any of the sessions.

NEW CASTLE SANITARIUM

Telephone 3621

NEW CASTLE, KY.

For the care of

CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the American Hospital Association
Member of the American Assn. of Nursing Homes
Licensed and Approved by the State of Kentucky

SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE

PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS

24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES

New Selectemp Modulated Steam Heat With Filtered Air For Maximum Comfort and Safety

Protected Throughout With Automatic Fire Detection and Alarm System

IRA O. WALLACE, Administrator

Foot-so-Port Shoe Construction and its Relation to Weight Distribution



• Insale extensian and wedge at inner carner af heel where suppart is mast needed.

• Special Supreme rubber heels are langer than mast anatamic heels and maintain the appearance af narmal shaes.

• The patented arch suppart canstructian is guaranteed nat ta break dawn.

• Innersales are guaranteed nat ta crack, curl, ar callapse. Insulated by a special layer af Texan which alsa cushians firmly and unifarmly.

• Faat-sa-Part lasts were designed and the shae canstructian engineered with arthapedic advice.

•NOW AVAILABLE! Men's canductive shaes. N.B.F.U. specifications. For surgeons and operating room personnel.

• By a special pracess, using plastic pasitive casts af feet, we make mare custam shaes far palia, club feet and all types af abnarmal feet than any ather manufacturer.

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

COUNTY SOCIETY REPORTS

JESSAMINE

The Jessamine County Medical Society met November 2, to elect officers for the coming year. M. C. Pentz, M.D., was elected president and J. S. Williams, M.D., was elected secretary of the society.

J. S. Williams, M.D., Secretary

PIKE

The Pike County Medical Society met October 18 in Pikeville. Twenty five members attended.

A motion that Pike County agree to take care of all private patient immunization records and furnish the Health Department with necessary records was made and seconded.

Carl Scott, M.D., Lexington, gave a talk on erythroblastosis.

G. N. Combs, M.D., Secretary-Treasurer

SCOTT

Robert Kinnaird, M.D., Lexington, was the guest speaker at the monthly meeting of the Scott County Medical Society Nov. 3. He spoke on Carcinoma of the Prostate.

A motion that the dentists and pharmacists be invited to meet with the society once a year was made, seconded and adopted. The January meeting was designated as the meeting time.

H. V. Johnson, M.D., Secretary

SCOTT

J. Campbell Cantrill, M.D., was elected president of the Scott County Medical Society at their December meeting in Georgetown.

Other officers elected for 1956 were: C. R. Lewis, M.D., Vice President; H. G. Wells, M.D., Delegate; F. W. Wilt, M.D., Alternate; W. S. Allphin, M.D., Censor, 3 years; H. V. Johnson, M.D., Secretary and Treasurer.

The society voted to protest, to the councillor and the Kentucky State Medical Association, against the purchase of polio vaccine after February 1956.

H. V. Johnson, M.D., Secretary

SHELBY-OLDHAM

The October meeting of the Shelby-Oldham County Medical Society was held at the Stone Inn in Simpsonville. Twenty members attended

the meeting.

The society named a nominating committee and a committee on resolution on the death of Lister Collins, M.D., Mount Eden. Dr. Collins died October 25, 1955.

A film "Cancer of the Mouth," was shown. The next meeting of this society will be held November 18, at the Stone Inn. L. T. Kurland, M.D., Bethesda, Md., will talk on Multiple Sclerosis.

C. C. Risk, M.D., Secretary.

In Memoriam

G. DARWIN CALLIHAN, M. D.

Prestonsburg

1880 - 1955

Dr. Callihan, 76, a bachelor physician who began practice 50 years ago, died Oct. 23.

He was graduated from the Eclectic Medical School in 1904. A native of Prestonsburg, Dr. Callihan was the son of a physician, and a brother of the late William R. Callihan, M.D.

D. RANDOLPH SKAGGS, M. D.

Ashland

1871-1955

Dr. Skaggs, 84, died in Ashland November 3.

A 1907 graduate of the Hospital College of Medicine, Dr. Skaggs had practiced in the mountains of Magoffin, Breathitt, Knott and Wolfe counties since his graduation. He retired eight years ago.

CLARENCE F. HALEY, M. D.

Brooksville

1887 - 1955

Dr. Haley, 68, died at his home in Brooksville, Oct. 10, of a heart attack.

Dr. Haley, a 1919 graduate of the University of Louisville Medical School, had practiced medicine in Bracken County since his graduation.

He was a charter member of the Brooksville Lions Club, a member of the Masonic Lodge and of the Brooksville Christian Church, secretary of the Bracken County Medical Society. Dr. Haley was a member of the courtesy medical staff at Hayswood Hospital and a member of the KSMA and the AMA.

J. J. MARSHALL, M. D.

Crittenden

1876-1955

Dr. Marshall died at St. Elizabeth Hospital at the age of 79. He had been in the hospital for the past month.

A graduate of the Louisville Medical School, Dr. Marshall confined most of his practice to the Crittenden community. In 1946 he resigned from practice.

He was a member of the Crittenden Christian Church and of the Crittenden Lodge of Free and Accepted Masons.

WANTED: Registered physical therapist, by Kentucky Rehabilitation Center at the University of Kentucky, Lexington, Kentucky. Contact Medical Director at Kentucky Rehabilitation Center, Inc., at the University of Kentucky or call Lexington 2-2200, Ext. 2401 for appointment.



1956 CONSTITUTION AND BY-LAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association.
Article III. Component Societies
Article IV. Composition of the Association
Article V. House of Delegates
Article VI. Sections and District Societies
Article VII Sessions and Meetings
Article VIII. Officers
Article IX. Funds and Expenses
Article X. Referendum
Article XI The Seal
Article XII. Amendments
Article XIII. Meaning of Term "County Societies"

BY-LAWS

Chapter I. Membership
Chapter II. Annual and Special Sessions of the Association
Chapter III. General Meeting
Chapter IV. House of Delegates
Chapter V. Election of Officers
Chapter VI. Duties of Officers
Chapter VII. The Council
Chapter VIII Committees
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

———*———

CONSTITUTION

Article I. Name of the Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge, and the advancement of medical science and charity, to the elevation of the standard of medical education and to the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and to the guarding and fostering of their material interest; to protect the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problem of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition of the Association

The Association shall consist of the members of the component societies, and the House of Delegates shall have authority to adopt By-laws regulating the admission and classification of members as deemed advisable.

Article V. House of Delegates

Section I. The House of Delegates shall be the legislative and business body of the Association and shall have the power, by a two-thirds vote of all the delegates present at that session to adopt By-laws to carry out the provisions of this Constitution.

Section 2. Delegates shall be members of and elected by component societies in accordance with the By-Laws. Officers of the Association and Delegates to the American Medical Association and the five immediate Past-Presidents shall be ex-officio members of the House of Delegates and entitled to vote.

Section 3. The Speaker or Vice-Speaker shall preside during the meetings of the House of Delegates. The Presiding Officer shall not be entitled to a vote except in the event of a tie vote.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VI. Sections and District Societies

The House of Delegates may provide for a division of the scientific work of the Association into appropriate Sections and for the organization of such Councilor District Societies as will promote the best interest of the profession, such societies to be composed exclusively of members of component societies.

Article VII. Sessions and Meetings

The Association shall hold an annual session and such special sessions as may be desirable in accordance with the By-Laws of the Association.

Article VIII. Officers

Section I. The Officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, and a Councilor from each Councilor

District that may be established and such other Officers as provided for in the By-Laws.

Section 2. The Officers of the Association shall serve for the term of office and subject to provisions as specified in the By-Laws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. The Officers of the Association shall be elected by the House of Delegates at the annual session of the Association and shall take office on the last day of the annual meeting.

Article IX. Funds and Expenses

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by an equal per capita assessment upon each county (component) society to be fixed by the House of Delegates by voluntary contribution and from other sources of revenue. Funds may be appropriated by the House of Delegates to defray the expenses of the Annual Session, for publication and for such other purposes as will promote the welfare of the Association and profession.

Article X. Referendum

The General Meeting of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a similar vote of its own members or after a like vote of the General Meeting, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question and be binding upon the House of Delegates.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Meaning of Term "County Societies"

Anywhere in the Constitution, Articles of Incorporation, or By-Laws in which the term county society, or county societies; component county society or component medical society appears, it shall be construed to mean component society.

BY-LAWS

Chapter I. Membership

Section 1. A member of this Association must be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association the name of the member shall be included in the official roster of the Association and the member shall be entitled to all the privileges of his class membership.

Section 2. Active Members. Active members shall comprise the active members of the component medical societies. To be eligible for active membership in any component county society the applicant must be:

A. A doctor of medicine who is licensed to practice medicine in the State of Kentucky and who is of good moral and professional standing.

B. A medical officer of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

C. Any doctor of medicine engaged in scientific or professional pursuits whose principles and ethics are consonant with those of the State Association.

Section 3. Associate Members. Associate members shall consist of associate members of the component medical societies who are not eligible for active membership and who are qualified under one or more of the following groups:

A. An intern, resident or teaching fellow who is a Doctor of Medicine but who is not licensed to practice medicine in the state.

B. A person who is not a Doctor of Medicine but who is engaged in scientific, professional or other pursuits, whose principles and ethics are consonant with those of the Association.

C. A Doctor of Medicine residing and practicing outside the area covered by the component society and who is an active member in good standing in his own component society.

Associate members shall not have the right to vote nor to hold office. The Council shall, from time to time, determine the amount of dues to be charged. Associate members shall receive the Journal and the publications of the Association.

Section 4. Emeritus Members. Component societies may elect as a Member-Emeritus any Doctor of Medicine who has retired from active practice and who has previously maintained active membership in good standing in his society. Emeritus members shall not have the right to vote nor to hold office and shall not

pay dues. They shall receive the Journal and other publications of the Association.

Section 5. Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The Council shall determine, from time to time, the amount of dues to be charged. Student members shall receive the Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

Section 6. Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent State Medical Association and who has participated in the program of the Scientific Session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privilege on the floor in all scientific sessions.

Section 7. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any annual session upon invitation of the Association or its Council and shall be accorded the privilege of participating in all of the scientific work of that session.

Section 8. The name of a physician upon the properly certified roster of members or list of delegates, of a chartered county society which has paid its annual assessment, shall be prima facie evidence of his right to register at the Annual Session in the respective bodies of this Association.

Section 9. No persons who are under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its rolls of membership, shall be entitled to any of the rights or benefits of this association, nor its proceedings until such time as he has been relieved of such liability.

Section 10. Each member in attendance at the Annual Session shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member or delegate shall take part in any of the proceedings of an annual session until he has complied with the provision of this section.

Chapter II. Annual and Special Sessions of The Association

The Association shall hold an Annual Session and such special session at such times and places as may be determined by the House of Delegates. All sessions shall be limited to the scientific, educational, legislative, economic and business activities of the Association. Such special sessions shall be held in accordance with the provisions of Chapter IV, Section I of the By-Laws.

Chapter III. General Meeting

The General Meeting shall include all registered active members, associate members and guests. Associate members and guests shall not have the right to vote on pending questions, but shall have equal rights with active members to participate in the proceedings and discussions. Each General Meeting shall be presided over by the President or in his absence or disability or upon his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the entire time of the sessions as far as may be, shall be devoted to papers and discussions relating to scientific medicine.

Chapter IV. House of Delegates

Section I. The House of Delegates shall meet annually at the time and place of the Annual Session of the Association and shall so fix its hours of meeting as not to conflict with the first General Meeting of the Association, or with the meeting held for the address of the President so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interest of the association and profession require, it may meet in advance or remain in session after the final adjournment of the General Meeting. The House of Delegates may be called into special session by the President with the approval of the Council and a special session of the House of Delegates shall be called by the President on a written request of the delegates representing fifty or more component county societies. When such special session is called, the Secretary shall mail a notice of the time and place and purpose of such meeting to the last known address of each member of the House of Delegates at least ten days before such special session.

Section 2. In the event there is no duly authorized delegate in attendance at the regular meeting of the House of Delegates the President shall consult any duly elected officer of the component society who is in attendance and with the approval of the Credentials Committee may appoint any active member of the component society in attendance at the meet-

ing as the delegate. In the event there is no duly elected officer of the component society in attendance, the President may make the said appointment with the approval of the Credentials Committee. All appointments made shall also be with the approval of the House of Delegates.

Section 3. A majority of the registered delegates shall constitute a quorum and all of the meetings of the House of Delegates shall be open to members of the Association. The House of Delegates shall have the right to go into executive session whenever such action is indicated in the judgment of the House of Delegates, except that active members of the Association shall have the right to attend all executive sessions.

Section 4. Each Resolution introduced into the House of Delegates shall be in writing and presented to the Secretary. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 5. No new business shall be introduced in the last meeting of the House of Delegates without unanimous consent of the Delegates except when presented by the Council. All new business so presented shall require three-fourths affirmative vote for adoption.

Section 6. It shall, through its officers, Advisory Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Session a stepping stone to further ones of higher interest.

Section 7. It shall consider and advise as to material interest of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in rel tion thereto.

Section 8. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who can be made reputable, has been brought under medical society influence.

Section 9. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 10. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

Section 11. It shall upon application provide and issue charters to county societies organized to conform to the spirit of the Constitution and By-Laws.

Section 12. In sparsely settled sections two or more County Societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The County Society thus combined shall not lose any of its privileges and representation. The active members of each County Society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the State Association.

Section 13. The state shall be divided into the following councilor districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Spencer, Taylor and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby and Trimble.

No. 8—Boone, Campbell and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott and Robertson.

No. 10—Fayette, Jessamine and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie and Whitley.

Councilor district meetings may be held as desired, and District Medical Associations may be organized as desired according to the districts outlined above.

Section 14. It shall have authority to appoint

committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 15. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 16. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

Chapter V. Election of Officers

Section 1. The President-Elect and the Vice-Presidents shall be elected for a term of one year. The Speaker and Vice-Speaker of the House of Delegates shall be elected for a term of three years. The Secretary and Treasurer shall be elected for a term of five years. The Councilors shall be elected for a term of three years and shall be limited to serving for not more than two consecutive terms. The terms shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice-President, Speaker or Vice-Speaker of the House of Delegates, or Councilor who has not been an active member of the Association for at least five years.

Section 2. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting continue until an election occurs in like manner.

Section 3. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of this Association shall be ineligible for any office for two years.

Section 4. The election of officers shall be held during the closing session at the regular annual meeting of the House of Delegates.

Section 5. During the last session of the House of Delegates the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the County Society Officers' Conference, or at some other appropriate place designated by the Council at least four months before the Annual Meeting. The Committee, in addition to such other sessions as it may choose to hold, will schedule an open meeting immediately after the close of the first session of the House of Delegates at each Annual Meeting. This open session shall be held in the same meeting hall, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Following this meeting, the Committee shall announce its final recommendations at the beginning of the second scientific session the following day, the Committee submitting one or more names for each officer to be elected. The House of Delegates will vote on the nominees at its second session. Additional nominations may be made from the floor by submitting the nominations without discussion or comment.

Section 6. The Delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating a Councilor for the Councilor District concerned. This committee shall hold a meeting open to all active members of Councilor District concerned who are in attendance at the meeting for the purpose of discussing the nomination for the Councilor to serve the District. Additional nominations may be made from the floor by any member of the House of Delegates when the Nominating Committee makes its report to the House of Delegates.

Chapter VI. Duties of Officers

Section 1. The President shall preside at all general meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Councilors in building up the county societies and in making their work more practical and useful.

Section 2. The President-Elect shall be a member of the Commiteee on Scientific Assembly. He shall become President of the Association at the next annual meeting of the Scientific Session following his election as President-Elect. He shall assist the President in visitation of county and other meetings and shall be ex-officio a member of the House of Delegates with the right to vote. In event of death, resignation, or if he becomes permanently disqualified, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at the next annual meeting of the Scientific Session of the Association.

Section 3. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation or removal, the Council shall elect one of the Vice-Presidents to succeed him.

Section 4. The Speaker of the House of Delegates of the Association shall preside at all meetings of the House of Delegates. He shall appoint all committees for the House of Delegates with the approval of the House of Delegates. He shall be an ex-officio member of all said committees. He shall perform such other duties as custom and parliamentary usage may require.

Section 5. The Vice-Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, resignation or removal of the Speaker, the Vice-Speaker shall automatically become Speaker of the House of Delegates.

Section 6. The Treasurer shall give bond for the trust imposed in him whenever the House of Delegates shall deem it requisite. He shall demand and receive all funds due the Association, together with the bequests and donations. He shall, under the direction of the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall in general subject to such direction have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or his Executive Secretary and shall be counter-signed by the Treasurer of the Association. Under unusual circumstances, when one or more of the above named officials are not readily available, the President of the Association or the Chairman of the Council is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Council. The Treasurer shall subject his accounts to an annual audit under the direction of the Council. He shall render an annual account of his doings and the state of all Association funds.

Section 7. The Secretary, acting with the Committee on Scientific Assembly, shall prepare and issue the program for and attend all meetings of the Association and of the House of Delegates and he shall keep minutes of their respective proceedings in separate record books. He shall charge upon his books the assessments against each component county society at the end of the fiscal year; he shall collect and make proper credits for the same and perform such other duties as may be assigned him. He shall be custodian of all record books and papers belonging to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which may come into his hands. He shall provide for the registration of the members and delegates at the Annual Session. He shall keep a card index register of all practitioners of the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association for publication. In so far as it is in his power he shall use the printed matter, correspondence and influence of his office to aid the Councilors in the organization and improvement of the county societies and in extension of the power and usefulness of this Association. He shall conduct the official correspondence, notify members of meetings, officers of their election, and committees of their appointments and duties. He shall be editor of the Kentucky Medical Journal. He shall employ such assistants as may be ordered by the Council or the House of Delegates. He shall annually make a report of his doings to the House of Delegates.

In order that the Secretary may be enabled to give that amount of his time to his duties which will permit of his becoming proficient, it is desirable that he shall receive some compensation. The amount of his salary shall be fixed by the House of Delegates.

Chapter VII. The Council

Section I. The Council shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall consist of the duly elected councilors. The President, the President-elect, the three Vice-presidents, the immediate Past-president, the Speaker of the House of Delegates, the Secretary, the Treasurer and the Delegates to the American Medical Association shall be ex-officio members of the Council with the right to vote. The Executive Committee of the Council shall consist of the President, the President-elect and the Secretary of the Association, together with the Chairman of the Council, Vice-chairman of the Council and two additional councilors to be elected annually by the Council.

Section 2. The Council shall hold daily meetings during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three councilors. It shall meet on the last day of the Annual Session of the Association for reorganization and for the outlining of the work for the ensuing year. At this meeting it shall elect a chairman and secretary, and it shall keep a permanent record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided which report shall include an audit of the ac-

count of the Secretary and Treasurer and other agents of this Association and shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. In the event of a vacancy in any office the Council may fill the same until the annual election.

Section 3. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the county societies and their members. The necessary traveling expenses incurred by Councilor in the line of his duties herein imposed may be allowed by the House of Delegates upon a proper itemized statement, but this shall not be construed to include his expense in attending the Annual Session of the Association.

Section 4. Collectively the Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates of the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or a county society upon which appeal is taken from the decision of an individual Councilor. Its decision in all such cases shall be final.

Section 5. The Council shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation and other important matters to the public and the lay press. Such communications shall be signed by the President of the Association and the Chairman of the Council as such.

Section 6. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Association and shall have authority to appoint such assistants to the editors as it deems necessary. It shall manage and conduct the Kentucky Medical Journal, which is the organ of the Association, and all money received by the Journal, the Councilor or any officer of the Association, shall be paid to the Treasurer of the Association on the first of each month.

Section 7. All reports on scientific subjects and all scientific discussions and papers read before the Association shall be referred to the Kentucky Medical Journal for publication. The editor, with the consent of the Councilor for the District in which he resides, may curtail or abstract papers or discussions, and the Council may return any paper to its author which it may not consider suitable for publication.

Section 8. All commercial exhibits during the Annual Session shall be within the control and direction of the Council.

Section 9. In the event the office of one of the District Councilors is vacated between the meetings of the House of Delegates, the President of the Association may call a meeting of the delegates of record in the Headquarters Office from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Council, which will elect a Councilor from them to serve until the next meeting of the House of Delegates.

Section 10. A Medico-Legal Administrator shall be appointed to serve for a term of three years by the Council of the Association. The Executive Committee of the Council shall act in an advisory capacity to the Administrator. The Association, through the Administrator, shall provide its members in good standing a defense against unjust professional liability suits upon request by a member physician involved. The Administrator, acting under the general direction of the Executive Committee, shall select and fix the compensation for an attorney who shall act as the general counsel in these matters and, if required, select additional counsel.

Chapter VIII. Committees

Section 1. The Standing Committees shall be as follows:

A Committee on Arrangements

A Committee on Scientific Assembly

A Committee on Public Information and Service

A Committee on Medical Service

A Committee to Study Constitution and By-Laws

A Legislative Committee

and such other committees as may be necessary. The Headquarters Office at 620 South Third Street, Louisville 2, Kentucky, shall be the headquarters for all committees and activities of the Association except as may be specifically authorized by the Executive Committee. Committees shall be appointed by the President of the Association in conference with the Secretary unless otherwise specified. The President, Secretary and General Manager, and Executive Secretary shall be ex-officio members of all committees serving without power to vote except as otherwise specified.

Section 2. The Committee on Arrangements shall consist of as many members and subcom-

mittees as are appointed by the President of the Association. No County medical society as such shall serve as the host society. The Chairman shall report an outline of the arrangements to the Secretary for publication in the program and shall make such announcements from time to time as may be desired. All expenses of the Committee on Arrangements shall be paid out of the Funds of the Association that are made available for that purpose.

Section 3. The Committee on Scientific Assembly shall consist of five members. The President of the Association shall be a member and Chairman of the Committee. The President-Elect shall be a member of the Committee. The President of the Association shall appoint one member for a three-year term. The Committee shall determine the character and scope of the scientific proceedings of the Association, subject to the provisions or the instructions of the House of Delegates or of the Association or to the provisions of the Constitution and By-Laws. Thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers, discussions and other business shall be presented which shall be adhered to by the Association as nearly as practicable.

Section 4. A Committee on Public Information and Service shall be appointed by the Council of the Association whose members shall serve at the discretion of the Council. The Council will annually designate its chairman. It shall be the duty of this committee to keep in active touch with public opinion. It shall keep the public informed of such developments that will constitute a service to the public. It shall promote such immediate and long-range educational programs, both to the public and within the profession, as are deemed in the best interest of both. Its work shall be done with dignity becoming a great profession and that wisdom which makes effective its work and influence.

Section 5. The Committee on Medical Service shall be appointed by the Council whose members shall serve at the pleasure of the Council. The Council shall annually designate the chairman of the committee. It shall be concerned with and responsible for all matters of Medical Education and Medical Economics which shall be within the province of the State Medical Association. It shall continually strive to serve as a liaison between the public and the Medical Association in those matters.

Section 6. The Committee to Study the Constitution and By-Laws shall make a constant study of the Constitution and By-Laws. The committee shall annually make a recommendation concerning changes which it feels should be made in order to keep the Constitution and By-Laws in line with changing conditions and circumstances.

Section 7. The Legislative Committee shall be appointed annually by the Council of the Association whose members shall serve at the pleasure of the Council. The Council shall each year designate the chairman of the committee. Under the direction of the Council, it shall represent the Association in securing and enforcing legislation in the interest of public health and the science of medicine.

Chapter IX. Assessments and Expenditures

Section 1. The assessment of thirty five dollars per capita on the membership of the component societies is hereby made the annual dues of this Association. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association on the first day of January in each year.

Section 2. Any county society which fails to pay its assessments, or make the report required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have the prior approval of the Council before they can become effective.

Chapter X. Rules of Conduct

The principles set forth in the Principles of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

Chapter XI. Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XII. County Societies

Section 1. All county societies now in affiliation with the State Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the state in which no component

society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one state-wide society of worthy Negro physicians who are not members of any county society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association. When more than one county society exists friendly overtures and concessions shall be made with the aid of the Councilor of the District if necessary and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Section 5. Each county society shall judge of the qualifications of its own members, but as such societies are the only portals to this Association, every reputable and legally registered physician who is practicing, or who will agree to practice nonsectarian medicine shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member. All active members of the component county societies shall be active members of the Kentucky State Medical Association.

Section 6. Any physician who may feel aggrieved by the action of the society of the county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, which upon a majority vote may permit him to become a member of an adjacent county society.

Section 7. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual councilors in district and county work, effort at conciliation and compromise shall precede all such hearings.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

Section 9. A physician living in or near a county line may hold membership in that county most convenient for him to attend, on permission of the county in whose jurisdiction he resides.

Section 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county, and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members snall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official position and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers each component society shall elect a delegate or delegates to represent it in the House of Delegates of the Association. The term of a delegate is from the beginning of the annual meeting of the House to which he was elected to serve to the beginning of the next annual meeting, but it may be for one or more years at the discretion of the county society. Each component society may be represented by one delegate for each 25 members in good standing or major fraction thereof. Provided, however, that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the secretary of this Association not later than 45 days before the next annual session. It shall be the obligation of the county medical society which elects delegates to serve more than one year to provide the KSMA Headquarters Office with a complete certified list of delegates to represent that county for that particular year.

Section 13. The Secretary of each county society shall keep a roster of its members and a list of non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keep-

(Continued on page 92)

Physicians Supplies Since 1882



One of the three high quality lines made by Hamilton Manufacturing. Quality equipment costs less in the long run. Reasonable terms available.

624 S. Third St. CLay 8855 Louisville, Ky.

CROCKER FELS

CITY VIEW SANITARIUM

For the diagnosis and treatment of mental and nervous disorders, alcoholism and drug addictions

Established in 1907 by the late John W. Stevens, M. D.

52 acres near city. Separate buildings for men and women

Two full time psychiatrists

Electric shock and insulin therapy in selected cases

Occupational therapy

Physiotherapy department

Adequate laboratory facilities

NASHVILLE :—: TENNESSEE

CONSTITUTION AND BY-LAWS

(Continued from page 90)

ing such roster the Secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each county society shall report to the Kentucky Medical Journal full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

Section 15. County societies may invite Dentists, Pharmacists, Funeral Directors, or other professional persons to become Associate Members of the County Society but such Associate Members shall not have any privileges or representations in the State Association.

Chapter XIII. Amendments

These By-Laws may be amended by any Annual Session by a two-thirds vote of all the delegates present at that session, after the amendment has been laid on the table for one day.

WANTED: A young M.D. for a County Seat town with only one M.D. who would certainly welcome another. Several surrounding towns of 500-800 population without M.D.'s. A 36 bed County Hospital will be completed in June or early July. For more information on this excellent opportunity and a rent-free office consisting of 6 rooms, 2 halls & bath in a modern Drug Store Bldg. on Main St. Contact Hayward Spinks, Owner Everley's Drug Store. Phone 273, Box 346, Hartford, Ky.

- **Tailored to your needs by a qualified, long-established organization**
- **Your opportunity to gain peace of mind from office and business worries**
- **Our services cover:**

  Tax Returns
  Bookkeeping and Monthly Reports
  Servicing Delinquent Accounts—**No Commission**
  Instructing Office Personnel
  Fee Analysis and Comparative Statistics
  Public Relations
  Setting Up New Practices and Partnerships
  Reviewing Plans for Retirement, Investments and Insurance

No charge for initial survey and no obligation to engage our services thereafter. Survey and subsequent contacts made only at your request. Service on month-to-month basis at reasonable cost.

Available

PROFESSIONAL BUSINESS MANAGEMENT

FOR DOCTORS ONLY

CLAYTON L. SCROGGINS ASSOCIATES
(MEDICAL - DENTAL MANAGEMENT)

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Alvin S. Haines

141 West McMillan Street
Cincinnati 19, Ohio
WOodburn 1-1010

I would like to know more about PBM.

Name .....

Address .....

..... Telephone .....

All Services Completely Confidential

for a spastic GUT

Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

CIBA
Summit, N. J.

2/2228M

MEDICAL HORIZONS TV Monday P.M. Sponsored by CIBA ABC-TV

Relax the best way ... pause for Coke



Time out for refreshment

DRINK Coca-Cola REG. U.S. PAT. OFF.



With "Premarin," relief of menopausal distress is prompt and the "sense of well-being" imparted is highly gratifying to the patient.

"Premarin"® —Conjugated Estrogens (equine)

5513

SECLUSION MATERNITY



Write for Information

MRS. EVA THOMPSON

4911 East 27th St.

Kansas City, Mo.

FAIRMOUNT HOSPITAL

FOR UNMARRIED GIRLS

Est. 1909

Private sanitarium with certified obstetrician in charge. All adoptions arranged through juvenile court. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

RADIUM

(Including Radium Applicators)

For All Medical Purposes

Est. 1919

Quincy X-Ray & Radium Laboratories

(Owned and Directed by a Physician-Radiologist)

HAROLD SWANBERG, B.S., M.D., Director

W. C. U. Bldg. Quincy, Illinois

WAYSIDE HOSPITAL

168 North Broadway

Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

APPROVED BY AMERICAN MEDICAL ASSOCIATION

STAFF

H. HALBERT LEET, M. D. JOHN H. ROMPF, M. D.

CARL WIESEL, M. D. IRVING A. GAIL, M. D.

EDWARD L. HOUCHIN, ADMINISTRATOR

Phone: 2-2050

when sniffles hit the classroom

AND
NASAL CONGESTION
MAKES YOUNGSTERS
MISERABLE



Neo-Synephrine®
HYDROCHLORIDE
Pediatric Nasal Spray
0.25% • 20 cc.
contains Zephiran® chloride 1:5000, antibacterial wetting agent and preservative far greater efficiency

Designed specifically for children*

Prompt and
Prolonged Decongestion
Sinus Drainage and Aeration

NO STING • NO SEDATION • NO EXCITATION

Plastic Unbreakable Squeeze Bottle
Leakproof, Delivers a Fine Mist

*Also well suited for adults who prefer a mild spray.

Winthrop LABORATORIES • NEW YORK 18, N. Y. • WINDSOR, ONT.

Neo-Synephrine (brand of phenylephrine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U.S. Pat. Off.



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Members of the American Hospital Association and National Association of Private Psychiatric Hospitals

Five modern buildings, separate for men and women. Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD, Hospital Administrator
J. F. HALLER, Manager

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M. D., Neuropsychiatrist Medical Director
T. J. SMITH, M. D., Associate

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465
334 W. BROADWAY
LOUISVILLE, KENTUCKY

WAbash 6725

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**
( ) **Centralized Bookkeeping** (Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**

OCULISTS' PRESCRIPTIONS EXCLUSIVELY

MUTH OPTICAL COMPANY

Prescription Opticians

We maintain our own manufacturing and grinding laboratory

665 S. 4th **Brown Hotel Building** **Louisville 2**

Clearview

On The Kratzville Road
EVANSVILLE, IND.

TELEPHONE 5-6181

A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.

SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery

ELECTROENCEPHALOGRAPH—CLINICAL LABORATORY — EKG AND BMR EQUIPMENT — STEREOSCOPIC X-RAY—HYDROTHERAPY

Albert J. Crevello, M. D.

Diplomate, American Board of Psychiatry & Neurology, Inc.
MEDICAL DIRECTOR

the drug of choice

. . . as a tranquilizing (ataractic) agent in anxiety and tension states*

. . . in hypertension

RAUDIXIN

Squibb Whole Root Rauwolfia

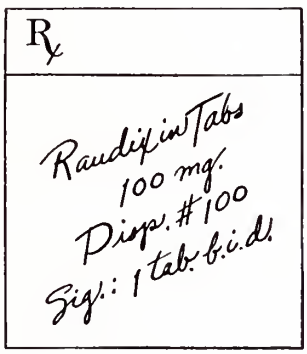
As a tranquilizing agent in office practice, Raudixin produces a calming effect, usually free of lethargy and hangover and without the loss of alertness often associated with barbiturate sedation. It does not significantly lower the blood pressure of normotensive patients.

In hypertension, Raudixin produces a gradual, sustained lowering of blood pressure. In addition, its mild bradycardic effect helps reduce the work load of the heart.

- **Less likely to produce depression**
- **Less likely to produce Parkinson-like symptoms**
- **Causes no liver dysfunction**
- **No serial blood counts necessary during maintenance therapy**

- Raudixin is not habit-forming; the hazard of overdosage is virtually absent. Tolerance and cumulation have not been reported.
- Raudixin supplies the *total* activity of the whole rauwolfia root, accurately standardized by a rigorous series of test methods. The total activity of Raudixin is not accounted for by its reserpine content alone.

Supply: 50 mg. and 100 mg. tablets, bottles of 100 and 1000.



*Ataractic, from ataraxia: calmness untroubled by mental or emotional excitation. (Use of term suggested by Dr. Howard Fabing at a recent meeting of the American Psychiatric Association.)

SQUIBB

"RAUDIXIN"® IS A SQUIBB TRADEMARK

the most complete optical service in kentucky

Southern Optical COMPANY
Since 1897
4th and Chestnut
334 W. Broadway
LOUISVILLE

GUILD OPTICIANS

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society

February 28, 29, March 1 and 2, 1956

Palmer House, Chicago

DAILY HALF-HOUR LECTURES BY OUTSTANDING TEACHERS AND SPEAKERS on subjects of interest to both general practitioner and specialist

PANELS ON TIMELY TOPICS TEACHING DEMONSTRATIONS

SCIENTIFIC EXHIBITS worthy of real study and helpful and time-saving TECHNICAL EXHIBITS.

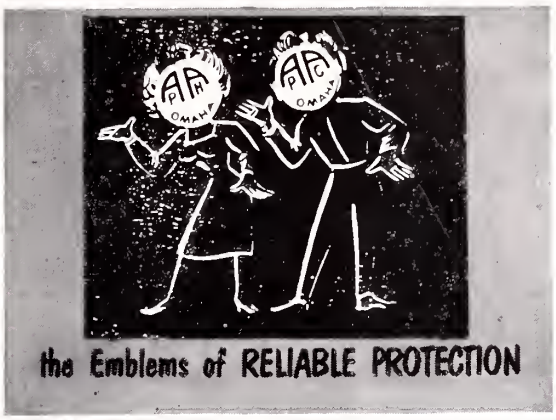
The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

BUYERS' GUIDE

Journal of the Kentucky State Medical Association, January, 1956

Abbott Laboratories 10, 11
American Meat Institute.....20
Ames Company, Inc.....103
Ayerst Laboratories 94
Bayer Company, (Division of Sterling Drug Co.).....102
Brayton Pharmaceutical Company.....19
Brown & Williamson Tobacco Co. 6
Burroughs Wellcome & Company.....23
Chicago Medical Society.....98
Ciba Pharmaceutical Company.....93
Cincinnati Sanitarium 76
City View Sanitarium 91
Clearview Sanitarium 96
The Coca-Cola Company 93
Crocker-Fels Company 91
Fairmount Hospital 94
Foot-So-Port Shoe Company.....80
The Keeley Institute 78
Ky. Rehabilitation Center, Inc.....81
Chas. B. Knox Gelatine Company.....101
Lakeside Laboratories 13
Lederle Laboratories 16, 17
Eli Lilly & Company 26
W. R. Long (Insurance Co.).....14
Medical Dental Business Bureau.....96
Mead Johnson & Company.....104
Medical Protective Company 81
Mid-South Post Graduate Medical Assembly 100
Muth Optical Company 96
New Castle Sanitarium 80
N. Y. Polyclinic Med. Sch. & Hosp.....78
Parke, Pavis & Company 2, 3
Chas. Pfizer & Company.....7, 22, 77
Physicians Casualty Association.....99
Pleasant Grove Hospital 96
Quincy X-Ray & Radium Laboratories..94
Schering Corporation 5, 24, 25
Clayton L. Scroggins 92
G. D. Searle & Company.....75
Sharp & Dohme, Inc.....9
Smith, Kline & French Laboratories....21
Southern Optical Company 98
E. R. Squibb & Sons.....97
Upjohn Company 15, 79
Want Ad (Howard Spinks).....92
Wayside Hospital 94
Winthrop Laboratories, Inc. 95

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your eligible dependents.



SINCE 1902

ALL PREMIUMS COME FROM PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

MAKE YOUR PLANS

Mid-South Postgraduate Medical Assembly

Hotel Peabody in Memphis, Tennessee

February 14, 15, 16, 17, 1956

Dr. William Perrin Nicholson, Jr., SURGERY, of Atlanta, Georgia

Dr. Rudolf J. Noer, SURGERY, of Louisville, Kentucky

Dr. Frank Glenn, SURGERY, New York, New York

Dr. Kenneth Pickrell, SURGERY, Durham, North Carolina

Dr. Henry G. Schwartz, NEUROSURGERY, St. Louis, Missouri

Dr. Arthur Grollman, MEDICINE, Dallas, Texas

Dr. T. S. Danowski, MEDICINE, Pittsburgh, Pennsylvania

Dr. Albert Segaloff, MEDICINE, New Orleans, Louisiana

Dr. B. Y. Glassberg, MEDICINE, St. Louis, Missouri

Dr. C. P. Rhoads, PATHOLOGY, New York, New York

Dr. George L. Sackett, X-RAY, Cleveland, Ohio

Dr. Warren E. Wheeler, PEDIATRICS, Columbus, Ohio

Dr. Harry Bakwin, PEDIATRICS, New York, New York

Dr. John C. Ullery, OBSTETRICS AND GYNECOLOGY, Columbus, Ohio

Dr. Edward D. Allen, OBSTETRICS AND GYNECOLOGY, Chicago Illinois

Dr. Alson E. Braley, OPHTHALMOLOGY, Iowa City, Iowa

Dr. David E. S. Wishart, ENT, Toronto, Canada

Dr. William M. Coppridge, UROLOGY, Durham, North Carolina

Dr. William H. Bickel, ORTHOPAEDIC SURGERY, Rochester, Minnesota

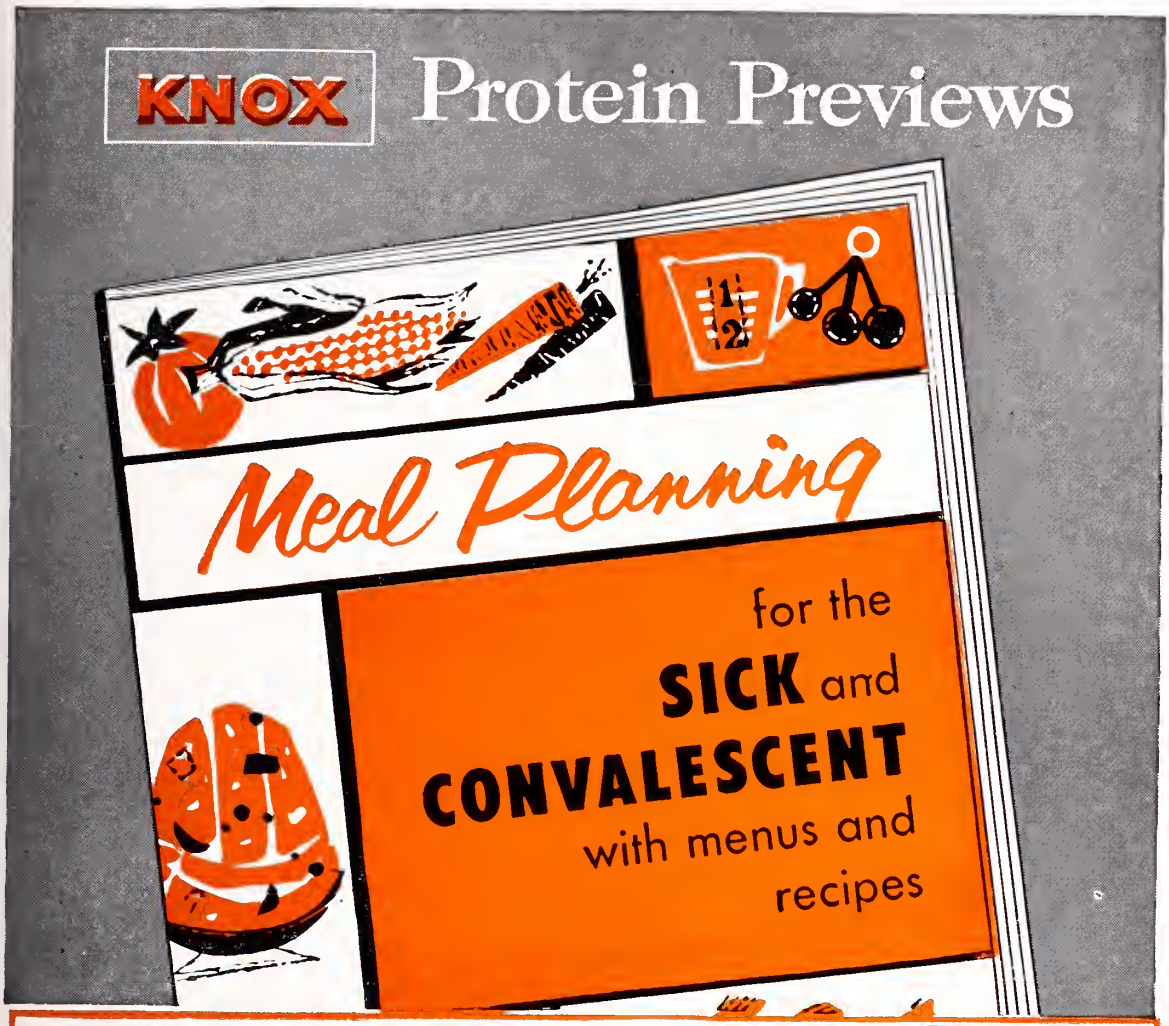
MAKE RESERVATIONS DIRECT WITH HOTEL PEABODY

Dr. Thurman Crawford, Secretary

869 Madison Avenue

MEMPHIS, TENNESSEE

KNOX Protein Previews



New Booklet Presents
Latest Facts on Feeding the Sick



Adequate nutrition during illness and convalescence is essential for recovery whether the patient is managed in the hospital or at home. In the latter case, physicians often must devote much time to instructing those responsible for caring for the sick in good nutritional practices.

"Meal Planning for the Sick and Convalescent" has been designed to relieve you of the need for repeating over and over again essential dietary facts. This new Knox booklet presents in layman's language the latest nutritional applications of proteins, vitamins and minerals, gives practical hints on serving food to adults and children, suggests ways to stimulate appetite and describes diets from clear liquid to full convalescent. Best of all it offers the homemaker for the first time detailed daily suggested menus for each type of diet, plus 14 pages of tested nourishing recipes.

If you would like copies of this new timesaving Knox booklet for your practice, use the coupon below.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Department SJ-13
Johnstown, N. Y.

Please send me.....copies of the new Knox "Sick and Convalescent" booklet.

YOUR NAME AND ADDRESS



little

How to win friends ...



The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

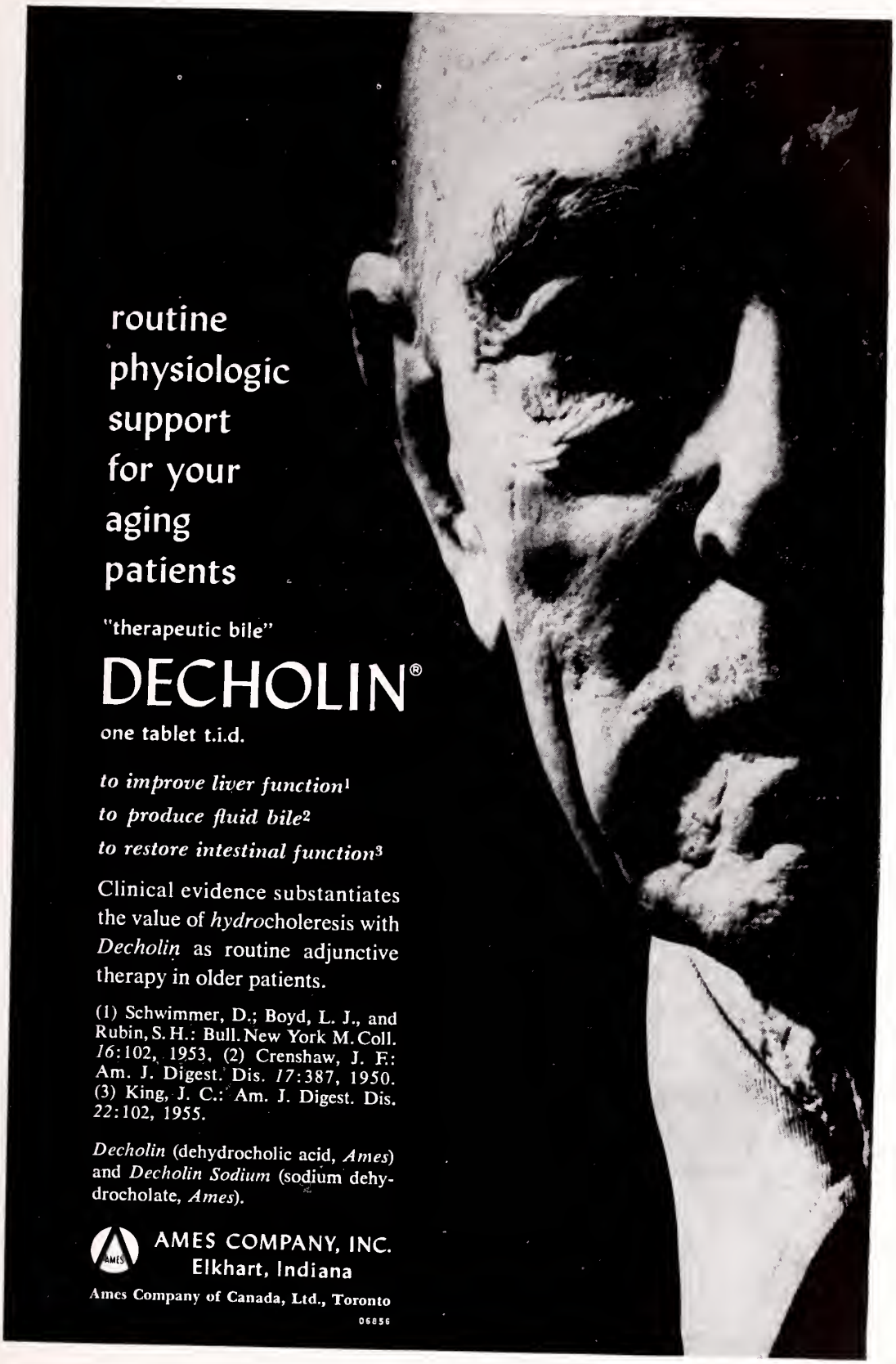
15¢ Bottle of 24 tablets (2½ grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION

of Sterling Drug Inc.

1450 Broadway, New York 18, N. Y.


routine
physiologic
support
for your
aging
patients
"therapeutic bile"
DECHOLIN®
one tablet t.i.d.
to improve liver function[1]
to produce fluid bile[2]
to restore intestinal function[3]
Clinical evidence substantiates the value of hydrocholeresis with Decholin as routine adjunctive therapy in older patients.
(1) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. 16:102, 1953. (2) Crenshaw, J. F.: Am. J. Digest. Dis. 17:387, 1950. (3) King, J. C.: Am. J. Digest. Dis. 22:102, 1955.
Decholin (dehydrocholic acid, Ames) and Decholin Sodium (sodium dehydrocholate, Ames).
AMES COMPANY, INC.
Elkhart, Indiana
Ames Company of Canada, Ltd., Toronto
06856

Sick patients

need food for therapy

THAT MAN MUST EAT to remain well is a concept as old as medicine. But only recently has it been established (1) that nutritional needs are increased in illness; (2) that food sufficient to meet these needs is well utilized, and (3) that therapeutic nutrition prevents many of the debilitating effects of disease and injury.

Unfortunately, because of the anorexia accompanying illness, effective nutritional therapy requires added care on the part of the physician. Food comes from familiar kitchens and lacks the impressive aura of more dramatic therapeutic agents. Thus it is often difficult to convince the patient that food, too, is therapeutic —that although drugs may arrest disease, only food can repair the ravages of disease.

Whatever the nutritional problem—whether caused by anorexia, mechanical difficulty in eating or limitation of gastric capacity or tolerance—only an assured food intake will solve it. The use of Sustagen, a food formulated for therapeutic nourishment, will overcome many difficulties in the therapeutic feeding of sick patients. A foundation for therapy thus may be established.

The development of Sustagen exemplifies the continuous effort of Mead Johnson & Company to provide the medical profession with products basic to the management of illness and the restoration of health.

Sustagen

Therapeutic Food for Complete Nourishment

Sustagen® is the only single food which contains all known nutritional essentials: protein, carbohydrate, fat, vitamins and minerals. It may be given by mouth or tube as the only source of food or to fortify the diet in brief or prolonged illness.

Sustagen

repairs tissue
restores appetite
overcomes asthenia

in

cirrhosis
peptic ulcer
geriatrics
infections
trauma
chronic disease

MEAD SYMBOL OF SERVICE IN MEDICINE

MEAD JOHNSON & COMPANY, EVANSVILLE 21, INDIANA, U.S.A.

KSMA ANNUAL MEETING, SEPTEMBER 18-20, 1956

The Journal OF THE KENTUCKY STATE MEDICAL ASSOCIATION

COLLEGE OF PHYSICIANS LIBRARY
MAR 12 1956
OF PHILADELPHIA

VOL. 54 FEBRUARY, 1956 NO. 2

Contents

SCIENTIFIC ARTICLES

CLINICAL AND METABOLIC EFFECTS OF PREDNISONE AND PREDNISOLONE IN RHEUMATOID ARTHRITIS, David H. Neustadt, M.D., Robert McClendon, M.D. F. Albert Olash, M.D., and Maurice Best M.D. 131
SEASONAL ALLERGY, Maurice Kaufmann, M.D., and Lloyd D. Mayer, M.D. 137
SURGICAL MATURATION OF THE ILEOSTOMY, Hart Hagan, M.D., F.A.C.S., and William H. Hagan, M.D., F.A.C.S. 144
CONGENITAL MUCOSAL DIAPHRAGM OF THE PYLORIC ANTRUM, W. T. Swartz, M.D., and R. D. Shepard, M.D. 149
THE OPEN METHOD OF BURN THERAPY, John Calvin Weeter, M.D. 155
MANAGEMENT OF THE UNCONSCIOUS PATIENT, Thomas M. Marshall, M.D. 157
BRUCE UNDERWOOD—THE PROGENITOR OF PROGRESS 164

EDITORIALS

BON VOYAGE 165
MEDICAL STATESMANSHIP OR MEDICAL POLITICS 166

ORGANIZATION SECTION

Society Officers Meet is March 29 167
Nominating Committee to Hold Meeting 169
Dr. Troutman is Secretary Pro tem 169
Awards Committee to Meet in March 170
AMA Offers Choice of 10 Journals 170
Chandler Backs UK Medical School 170
Radio Transcription Series Planned 170
14th District to Have April Meeting 170
First District to Meet in Paducah 170
LACMA Establishes MD Loan Program 171
WHAS Honors Frank M. Gaines, M. D. 171
Journal Criticizes Ike Questionnaire 171

REGULAR DEPARTMENTS

President's Page 112, In the Books 116, Washington News Digest 122, News Items 172, County Society Reports 174, In Memoriam 178, Pertinent Paragraphs 182



YEARS AGO when the physician fought to bring a patient through a siege of pneumonia there was little he could do but help conserve the patient's strength, make him comfortable . . . and hope for the best.

In fact, the doctor sadly signed death certificates for 33 out of every 100 pneumonia patients he treated. For those who survived, recovery was slow and expenses were high. The cost of an average case was about $1,000, including three or four weeks' time lost away from work.

Happily, this grim picture has changed. Under the onslaught of sulfa drugs . . . *and now the antibiotics* . . . pneumonia has steadily lost ground. Now, uncomplicated cases clear up in four to five days. And instead of losing 33 out of every 100 cases, the doctor saves all but a very few.

Just as striking as the cut in deaths and disability is the cut in the *cost* of *curing* pneumonia. More and more patients can now be cared for at home. As a result, the average case of pneumonia may cost no more than $100 . . . including loss of income, the doctor's visits and the "expensive" new medicines!

Today, more than ever before, an investment in prompt and proper medical care may well represent one of the biggest bargains of your life.

Copyright 1956—Parke, Davis & Company

PARKE, DAVIS & COMPANY
Research and Manufacturing Laboratories Detroit 32, Michigan

Makers of medicines since 1866

There are few subjects on which the general public is more uninformed (or perhaps *mis*informed) than the cost of modern medical care.

People have always grumbled about medical bills—and they probably always will, to some extent. The trouble is they tend to see medical expense as a part of sickness—something that certainly gives them no pleasure—rather than the price of enjoying good health.

But the real economics of the situation—what the patient gets for what he pays—proves that today's medical bill usually turns out to be one of the really big bargains of his life.

The latest Parke-Davis advertisement, reproduced here, cites the amazing decline in the cost of curing pneumonia to illustrate the remarkable value represented by your patient's investment in prompt and proper medical care.

This message will reach an audience of millions of readers in mass-circulation magazines such as LIFE and the SATURDAY EVENING POST. Reprints, in small folder form, are promptly available to physicians on request.

PARKE, DAVIS & COMPANY *Detroit 32, Michigan*

The JOURNAL of the

Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR PRO TEM: W. B. TROUTMAN, M. D. MED. EDITORIAL EDITOR: S. A. OVERSTREET, M.D.
MANAGING EDITOR: J. P. SANFORD BOOK REVIEW EDITOR: WALTER S. COE, M.D.
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D. ORGANIZATION EDITOR: BARBARA N. MORGAN
CASE DISCUSSIONS EDITOR: J. C. BELL, M.D. PUBLISHER: J. G. DENHARDT, BOWLING GREEN

ADVISORY COMMITTEE TO THE EDITOR

Richard J. Rust, M. D. Guy Aud, M. D., Chairman James E. Hix, M. D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1958	Term Expires July 1, 1957	Term Expires July 1, 1956
Henry B. Asman, M.D.	Carey C. Barrett, M.D.	Everett H. Baker, M.D.
Richard Elliott, M.D.	Joe Bush, M.D.	John L. Dixon, M.D.
Rankin Blount, M.D.	Allen E. Grimes, M.D.	George G. Greene, M.D.
Marion F. Beard, M.D.	Richard F. Grise, M.D.	R. Arnold Griswold, M.D.
Glenn Bryant, M.D.	Billy Keller, M.D.	O. Leon Higdon, M.D.
Douglas Scott, M.D.	A. J. Miller, M.D.	James M. Keeton, M.D.
William C. Buschemeyer, M.D.	Robert Reeves, M.D.	Frank Moore, M.D.
Harry D. Abell, M.D.	Charles R. Yancey, M.D.	Alvin C. Poweleit, M.D.

Editorial and Business Offices, 620 S. Third St., Louisville, Kentucky

Subscription $6.00 per year Single Copy .80

KENTUCKY STATE MEDICAL ASSOCIATION OFFICERS—1955-56

Gant Gaither, 109½ East 7th Street, Hopkinsville ..... President
Richard R. Slucher, Buechel ..... President-Elect
Clyde C. Sparks, M.D., Mayo Arcade Ashland ..... Immediate Past President
Everett Baker, 408 Brown Bldg., Louisville ..... Vice-President
Nathaniel Bosworth, 117 S. Ashland, Lexington ..... Vice-President
Howell J. Davis, 330½ Allen, Owensboro ..... Vice-President
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Secretary-Editor Pro tem
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Treasurer
Charles A. Vance, 271 W. Short Street, Lexington ..... Speaker—House of Delegates
E. W. Jackson, 333 Broadway, Paducah ..... Vice Speaker—House of Delegates
J. Vernon Pace, 709-10 Citizen's Bank Bldg., Paducah ..... Chairman of the Council
Delmas M. Clardy, Hopkinsville ..... Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan	1956
Alternate to be Appointed	1956
W. Vinson Pierce, 33 E. Seventh St., Covington	1957
Leon Higdon, 333 Broadway, Paducah, (Alternate)	1957

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Building, Paducah	1956
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1958
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Carlisle Morse, 3612 Lexington Road, Louisville	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1958
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1957
Ninth District	J. M. Stevenson, Brookville	1958
Tenth District	J. Farra Van Meter, 183 N. Upper Street, Lexington	1958
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1958
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Charles B. Stacy, Pineville	1957

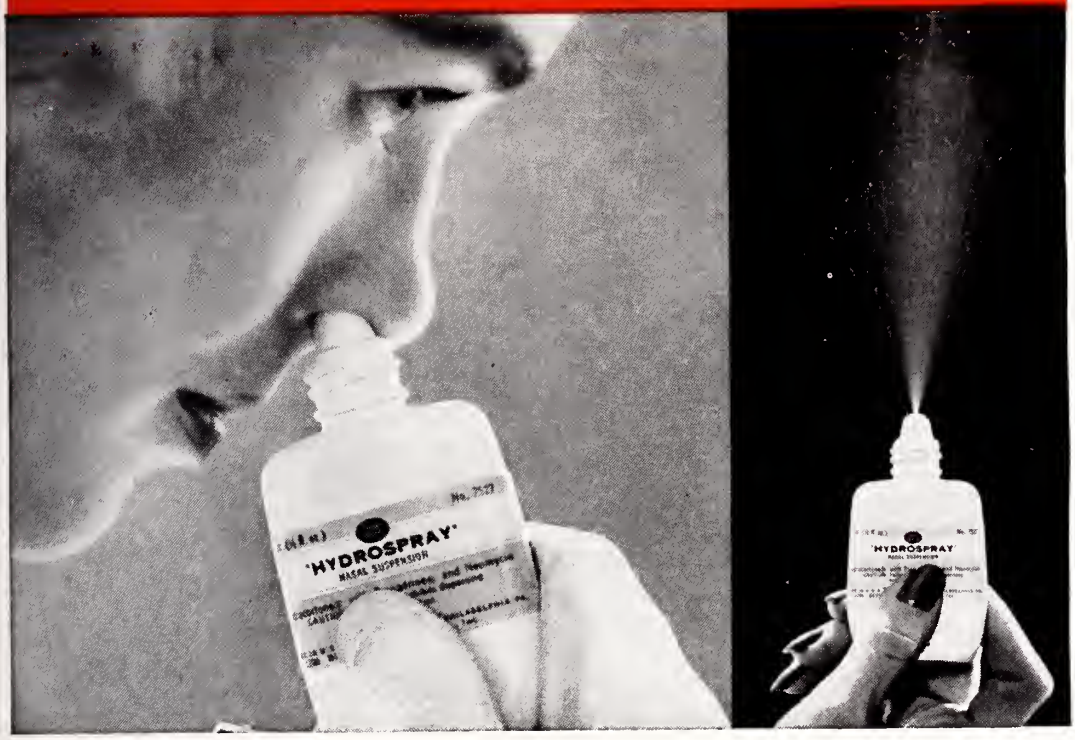
Entered as second-class matter, Oct. 22, 1906, at the Post Office at Bowling Green, Ky., under act of Congress, Mar. 3, 1897. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

'Hydrospray' NASAL SUSPENSION

(HYDROCORTONE® WITH PROPADRINE® AND NEOMYCIN)

Anti-inflammatory—
Decongestant—Antibacterial

MAJOR ADVANTAGES: New synergistic anti-inflammatory, decongestant and antibacterial formula. High steroid content assures effective response.



Topically applied hydrocortisone[1] in therapeutic concentrations has been shown to afford a significant degree of subjective and objective improvement in a high percentage of patients suffering from various types of rhinitis. HYDROSPRAY provides HYDROCORTONE in a concentration of 0.1% plus a safe but potent decongestant, PROPADRINE, and a wide-spectrum antibiotic, Neomycin, with low sensitization potential. This combination provides a three-fold attack on the physiologic and pathologic manifestations of nasal allergies which results in a degree of relief that is often greater and achieved faster than when any one of these agents is employed alone.

INDICATIONS: Acute and chronic rhinitis, vasomotor rhinitis, perennial rhinitis and polyposis.

SUPPLIED: In squeezable plastic spray bottles containing 15 cc. HYDROSPRAY, each cc. supplying 1 mg. of HYDROCORTONE, 15 mg. of PROPADRINE Hydrochloride and 5 mg. of Neomycin Sulfate (equivalent to 6.5 mg. of neomycin base).

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.

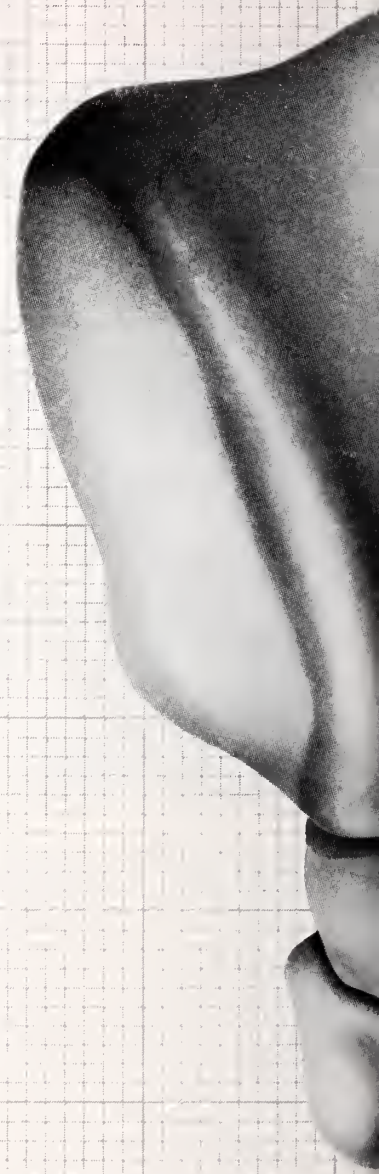
for a greater margin of security in corticosteroid therapy

- minimizes sodium retention edema
- dietary regulation seldom necessary

in **rheumatoid arthritis:** better relief of pain, swelling, tenderness; diminishes joint stiffness

intractable asthma: better relief of bronchospasm, dyspnea, cough; increases vital capacity

collagen diseases and allergies: hormone benefits with decreased electrolyte side effects



METICORTEN is available in the following forms:
1 mg., 2.5 mg. and 5 mg. tablets
2.5 mg. and 5 mg. capsules

*T.M.

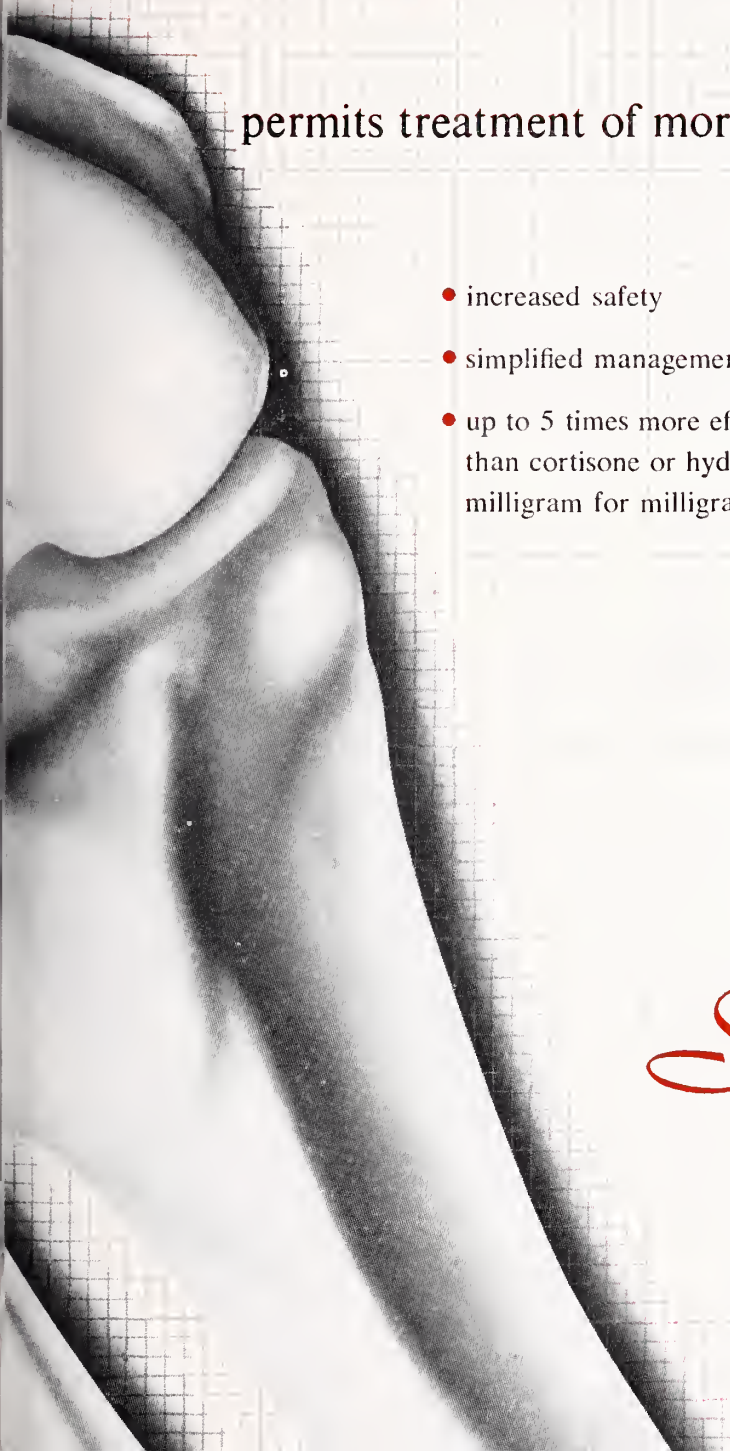
MC-J-66-1255

rather than cortisone

or hydrocortisone

METICORTEN*

PREDNISONE



permits treatment of more patients

- increased safety
- simplified management
- up to 5 times more effective than cortisone or hydrocortisone, milligram for milligram

Schering

President's Page

During my tenure of office I had not thought to be required to say good-bye officially to our very fine Secretary of the Kentucky State Medical Association and Kentucky Health Commissioner. But so it is.

When these pages unfold Bruce Underwood, M. D., will have left us. He will be at a new position in Washington, D. C., with the Department of Health, Education and Welfare, lending his keenly executive mind to those problems of the Hill-Burton section of USPHS that will be submitted to him.

We can not blame him for finding a better place, a higher salary and a more secure future. We can only blame ourselves for not giving him these things that he should have had here in Kentucky. This fault lies with a numerically small, very small element. 'Tis a pity they should have prevailed.

The die is cast and we both go forward our own ways, he to new endeavors where his strong personal integrity, his forthrightness and efficiency must certainly find acclaim; we forward in a new uncharted course in our state organization.

We have, of course, a wide field of fine physicians, especially in Louisville who can supply us a part time secretary over our present executive secretary, to give us proper balance and dignity in our office and Journal.

He has a young life wide open before him, full of opportunities in public health service to which his life is dedicated. With him, from his home state of Kentucky, go all our good wishes, our faith in him and the certainty that he will make us proud to have had him as our friend and officer.

Grant Gaither

PRESIDENT

NOW IN TWO POTENCIES

for more precise dosage

NEW  1 mg. *pink* tablet |  5 mg. tablet

MOST POTENT ANTI-RHEUMATIC

Sterane*

Both tablets are deep-scored and of the
SAME DISTINCTIVE "FINGER-GRIP" SIZE AND SHAPE
for ease of handling and breaking by arthritic fingers.

anti-rheumatic/anti-allergic/anti-inflammatory

supplied: **Pink,** 1 mg. oral tablets, bottles of 100.
White, 5 mg. oral tablets, bottles of 20 and 100.

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

*brand of prednisolone

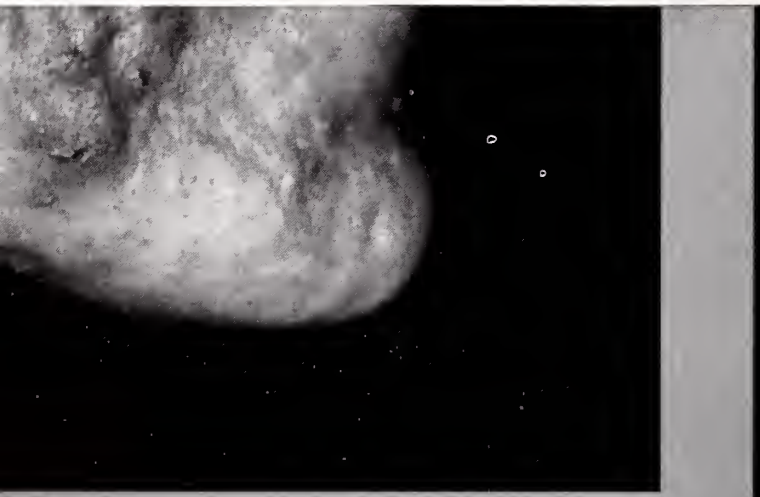
in **acne**
eczemas
dry skin

why not use the most effective vitamin A?



aqueous*
vitamin A is
a superior form
of vitamin A

aquasol A capsules



vitamin A
in high dosage
is effective
in many
hyperkeratotic lesions

*oil soluble vitamin A made water-soluble with sorethytan esters; protected by U.S. Patent No. 2,417,299.

samples and detailed literature upon request

u. s. vitamin corporation
(Arlington-Funk Laboratories, division)
250 East 43rd St., New York 17, N.Y.

better and more rapidly
absorbed and utilized,
better tolerated . . .

clinical evidence establishes
(as shown in chart below) that
aqueous vitamin A, as
available in Aquasol A Capsules,
provides . . .

up to 300% greater absorption
100% higher liver storage
80% less loss through fecal excretion

only **1/2** to **1/10** as much aqueous vitamin A is needed

	aqueous vitamin A**	ordinary oily vitamin A
acne	25,000 to 50,000 units daily	up to 500,000 units daily
eczema chronic	25,000 to 50,000 units daily	50,000 to 500,000 units daily
excessively dry skin	60,000 to 100,000 units daily	100,000 to 300,000 units daily

**Aquasol A Capsules (aqueous natural vitamin A) was one of the products used in these studies.

only **1/2** to **1/3** the treatment time is required for aqueous vitamin A

aquasol A capsules

three separate high potencies of natural vitamin A per capsule . . .
in water-soluble form:

25,000 U.S.P. units **50,000 U.S.P. units** **100,000 U.S.P. units**



bottles of 100, 500 and 1000 capsules



PATHOLOGY: Edited by W. A. D. Anderson, M.A., M.D., F.A.C.P.; Second Edition, 1953; The V. C. Mosby Company, St. Louis. 1393 pages, 1241 illustrations and 10 color plates; $16.00.

This book, written by 33 experienced, authoritative individuals, is essentially a textbook of human pathology.

The scope of the subject matter is huge. There are numerous books on pathology of the diseases of one anatomical system, or even one organ, that are comparable in size and larger than this volume. However, a striking feature is the enormous amount of subject matter in one book. This was accomplished by brevity and fine print.

The time-honored division of the subject of pathology into the two viewpoints—general pathology and special pathology—is avoided. Hence the organization is heterogeneous. Some chapters deal with the diseases of an anatomical system; others with an organ; others with a disease entity involving several anatomical systems; and others with fundamental disturbances common to the various tissues of the body. These are so few and brief as to be of questionable value.

The illustrations are excellent and informative. Only a negligible number are drawings. The outstanding features of the volume are the thorough presentation of disease entities, the great amount of subject matter in one volume, and a style of writing that is easily read. Each chapter is well supplied with references. In general and comparatively speaking the text is excellent.

A. J. Miller, M. D.

A REVIEW OF PRESENT-DAY PSYCHOLOGY—edited by A. A. Roback; Philosophical Library; 1955; 995 pages; $15.00.

The editor of this volume has done an outstanding job of selecting his authors and choosing his topics so that the reader is afforded a sweeping view of the modern psychological scene. The contributors are eminently qualified for their special fields and in general, they have succeeded in fitting their material to the requirements of clarity and brevity.

The volume includes chapters on 40 different topics which cover a wide range of material. Such broad topics as abnormal psychology and social psychology receive attention. Highly specialized topics such as the psychology of art and the psychology of religion are also treated. In general each author seems to follow a plan in which a brief historical development of the topic is presented, followed by present trends, and then by predictions as to future developments and promising avenues for future investigation.

Not all topics receive an equal degree of adequacy of treatment, and a few topics might profitably be pursued elsewhere with no more time and effort expended. In some cases, the breadth of the topic precludes satisfactory coverage in the space allotted, and the material consists more of enumeration than exposition of the items included.

The general reader might profitably read this book carefully since it encompasses material within the scope of the non-professional. For those who have some familiarity with the field it will serve as a good "refresher." For those interested in pursuing further a particular topic it will prove valuable. For this latter purpose the extensive bibliographies at the end of each chapter provide ample leads for more exhaustive examination.

Edmond F. Erwin, Ph.D.

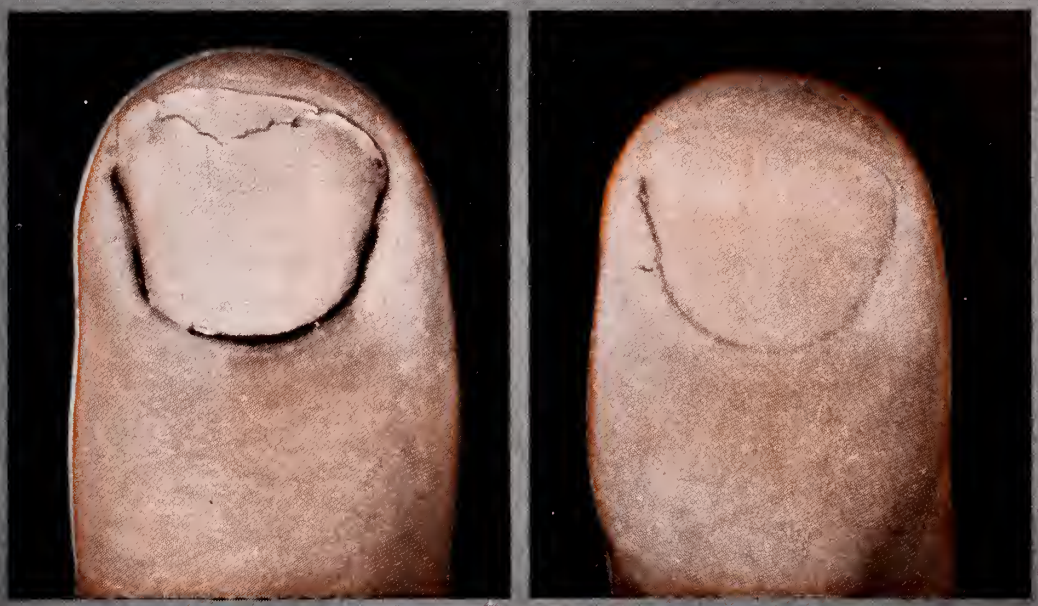
CANCER CELLS: by E. V. Cowdry, Director, Wernse Cancer Research Laboratory Washington University, St. Louis; W. B. Saunders Company, Philadelphia and London, 1955, 677 pages. $16.00.

This author has long been known to students of cytology, histology and gerontology through his authoritative textbooks and numerous scientific papers on these and other related subjects. His present book summarizes practically all that is currently known about cells—both normal and malignant.

It is a scholarly, painstaking, sometimes pedantic, review of well over 2000 pertinent papers (all completely listed in the bibliography) organized and analyzed by an investigator with almost four decades of experience in the investigation of cells. It describes the investigations of botanists, bacteriologists, protozoologists, embryologists, geneticists, biologists, pathologists, tissue culture experts, biochemists, cytochemists, clinicians and radiologists as

(Continued on page 118)

KNOX Protein Previews



New Study Shows Gelatine
Restores Brittle Fingernails to Normal



Directions for making the Knox Gelatine drink in every package

Brittle, fragile or laminating fingernails are the bane of many a woman's existence. Yet this highly prevalent and distressing condition often has gone uncontrolled for lack of effective therapy. Now, you can promise these patients substantial relief in a large percentage of cases.

In a recent study[1] that confirmed previous work[2] Knox Gelatine was used to treat 36 women with fragile, brittle, laminating fingernails. The response was most gratifying. Except for three patients who discontinued the therapy, three diabetics, and two women who had congenital deformities, the splitting ceased and all other patients were able to manicure their nails to a full point by the time the study ended.

Optimal dosage proved to be one envelope (7 grams) of Knox Gelatine administered daily for three months. Improvement, however, was noted after the first month. If you would like more complete details of this work, just use the coupon.

1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Dept. SJ-14
Johnstown, N. Y.

Please send me a reprint of the article by Rosenberg and Oster with illustrated color brochure.

YOUR NAME AND ADDRESS

SOCIALIZED MEDICINE

May never come, but. . . Socialized Insurance is here to stay, and it has created a sizable Estate Handicap against the physician.

In the case of a young doctor with young children, this economic penalty may be as high as $40,000.00

But there is a solution, and the cost is no greater than the Social Security Tax. Write now for complete information

— — — — — — — — — — —

W. R. LONG & ASSOCIATES

1534 Bardstown Road—Louisville, Ky.

Without obligation to me I would like to have more information about the solution to the Social Security problem of the young doctor. I am in good health and was

born .....
Month Day Year

Name.....

Address.....

IN THE BOOKS

(Continued from page 116)

they pertain to the common effort to elucidate the nature of malignancy.

The work is logically organized, beginning with an explanation of the distinction between malignant and benign tumors and mentioning the properties of malignant cells. It gives examples of the distribution of malignant potentialities in normal cells and of known carcinogens and the theories concerning their action. It goes on to discuss the susceptibility of normal cells to carcinogens and to consider the latent periods and factors modifying the production of cancers. Finally it outlines data on diagnosis, prevention and treatment and gives a chronological review of the high-lights of cancer research, with an estimate of its present trends, handicaps and possibilities. Each chapter is succinctly summarized.

An appendix is provided which supplies some references which will enable workers to proceed with their studies armed with the best available information.

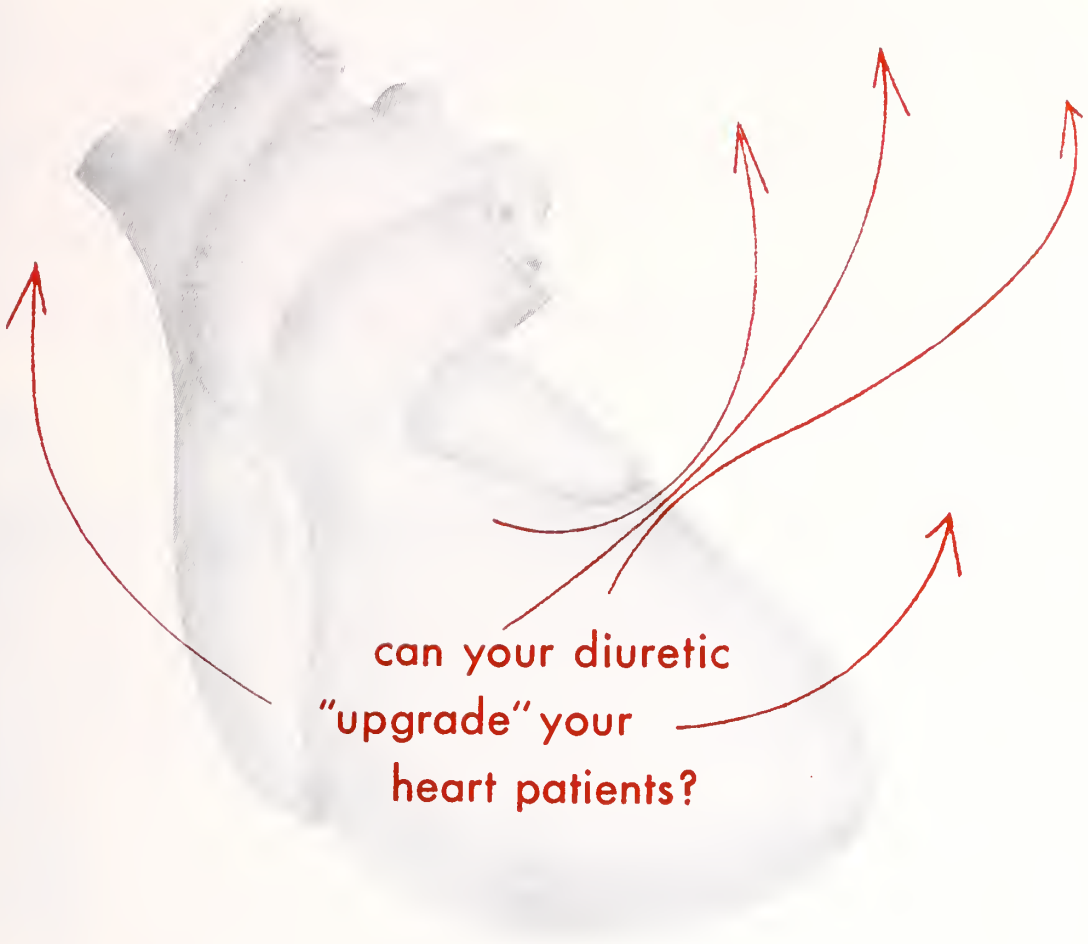
The physician or investigator who has been particularly interested in cancer will find that he is more or less familiar with most of the facts and ideas presented in this book. However, unless he has an unusually complete and well organized reprint file, he will find this an invaluable reference source. It is replete with lists and tables and presents, with an admirable scientific impartiality, all sides of many controversial issues, together with appropriate and perspicacious comment.

The busy clinician, whose principal interest is in the diagnosis and treatment of cancer in patients, will be ill-advised to invest much more of his reading time in this book than is required to familiarize himself with its contents by reading the chapter summaries.

John D. Allen, Jr., M. D.

The name of Carroll L. Witten, M.D., Louisville, was inadvertently omitted from the December "In the Books" section. Dr. Witten reviewed the book, PRACTITIONERS CONFERENCE VOLUME 1 which appeared on page 1040.

A subscription campaign for registered nurses has been launched by the national **Today's Health** (magazine) Committee of the Woman's Auxiliary. A two dollar rate will be featured during January, February and March. Nurses will be contacted by WA members either in person or by phone.



know your diuretic

fewer restrictions of activity are the benefit of prolonged use of those diuretics effective over the entire range of cardiac failure. The organomercurials—parenteral and oral—improve the classification and prognosis of your decompensated patients. Diuretics of value only in milder grades of failure, or which must be given intermittently because of refractoriness or side effects, are incapable of "upgrading" the cardiac patient.

TABLET
NEOHYDRIN®
BRAND OF CHLORMERODRIN
(18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA IN EACH TABLET)

for "...a new picture of the patient in congestive heart failure."*
replaces injections in 80% to 90% of patients
*Leff, W., and Nussbaum, H. E.: J. M. Soc. New Jersey 50:149, 1953.

a standard for initial control of severe failure

MERCUHYDRIN® SODIUM
BRAND OF MERALLURIDE INJECTION

Leadership in diuretic research
Lakeside LABORATORIES, INC., MILWAUKEE 1, WISCONSIN

88855

Be a Part of Kentucky's New Medical Development

The Louisville Medical Building

IN THE HEART OF THE MEDICAL CENTER

AT THE CORNER OF FLOYD AND GREY STREETS

The Lexington Medical Building

MIDWAY AMONG ALL THE HOSPITALS

SOUTH LIMESTONE AT THE 1400 BLOCK



"tailored for the doctors' needs"

- Doctor and patient on premises parking
- Air conditioned year round
- Fastest access to and from all leading hospitals
- Experience of five medical office buildings
- Office layout and partitions at no cost to doctors
- All window and glass on steel and concrete construction
- Future offices of many of Kentucky's most reputable doctors

Brochures available upon request

For brochures or information about floor plans, leases and other details please write or call

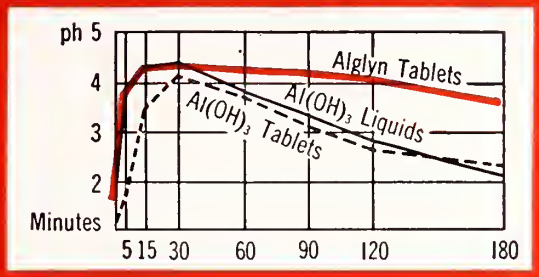
PROFESSIONAL BUILDING ASSOCIATES

408 *HENRY CLAY, LOUISVILLE* 2, *KY.*

MORTON STEINHARDT
President

TELEPHONE
WAbash 7389

Announcing Revision of N.N.R. Monograph for



2

ALGLYN®

dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayton PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

WASHINGTON NEWS DIGEST

Washington, D. C.—Bills that have been hanging fire in Senate and House Committees for over a year finally are getting attention as the Administration pushes its program for broader and more uniform medical care for the families of servicemen.

A new version of a bill was dropped in the hopper on the opening day of this session by Chairman Carl Vinson of the House Armed Services Committee. It was designed in part to supply answers to a number of questions growing out of earlier versions sponsored by the Defense Department. Actually it raised more questions, which only hearings and testimony from expert witnesses and debate on the floor of Congress can answer.

The bill (H.R. 7994) authorizes, as a matter of right, broad medical care for dependents of the armed forces as well as of Coast Guard, Public Health Service and Coast and Geodetic Survey personnel serving on active duty. (The bill would authorize health insurance only for dependents of latter three services.) Separate bills have been introduced in the past providing medical care for dependents of Coast Guard, PHS and Geodetic Survey, but this marks the first time they are brought into the same bill with military personnel.

In provision of services, the bill has no surprises over its predecessors. It calls for diagnosis, treatment of acute medical and surgical conditions, treatment of contagious diseases, and maternity and infant care.

On another point of major interest to physicians, the bill drops out all mention of the home-town medical care plan, which was a part of Mr. Vinson's earlier bill. That bill contemplated use of civilian hospitals and doctors for those dependents who were not near military medical facilities and who had not taken out health insurance, with the government paying part of the cost.

Another area of almost certain debate in the latest bill is the insurance features. There are these main points:

1. A serviceman may elect to rely entirely on the chance of finding space available in a military hospital or clinic for his family, or he may choose protection through an insurance plan.

2. The family deciding on insurance has its choice of going to a military hospital or using civilian resources. The uninsured family could be charged by the military for out-patient care, and would have to pay subsistence costs while in the hospital.

3. A serviceman taking insurance would pay 30% of monthly premiums for a basic plan covering his wife and children, and the entire premiums for coverage of dependent parents and parents-in-laws. Parents and parents-in-law who found space in a military hospital, however, would be admitted on the same basis as wives and children.

4. Catastrophic-type coverage, at additional premium.

5. To take care of long term illnesses, the bill provides for transfer of dependents to military facilities once they have used up benefits in an insurance plan. Or if such transfer isn't feasible, the government could pay the additional costs of private care.

The bill was introduced before the Defense Department had completed a survey of Blue Shield, Blue Cross and commercial plans to determine to what extent they could provide care under the bill. Conceivably the survey could further change the shape of an already much-revised piece of legislation.

President Eisenhower in his State of the Union message summed up the case for dependent medical care this way: "Much has been done to attract and hold capable military personnel, but more needs to be done." He also broadly outlined administration plans in the health field, with emphasis on more money for research and federal aid to medical schools and to provide research facilities for construction. With bipartisan bills along this line already before Congress, these proposals may move right along before adjournment in midsummer.

However, Congress might decide that for this year medical schools should settle for the $90 million of Ford Foundation money being made available to private schools to help strengthen teaching staffs.

By the same token, there was some question just how much Congress would vote for Hill-Burton hospital programs this session in the light of the $200 million Ford grants to some 3,500 non-profit hospitals.

A recent Public Health Service report indicates that states are now showing less preference for "public" Salk vaccine programs than they did a few months ago. The sixth allotment marked the high-point in "public" preference. Then came a slight but steady decline.

HydroCortone®

(HYDROCORTISONE, MERCK)

A valuable aid in rehabilitating the arthritic patient

MAJOR ADVANTAGES: Greater anti-rheumatic activity than cortisone; smaller doses produce clinical improvement faster and more uniformly.[1]



HYDROCORTONE is a practical long-term therapeutic measure in the majority of patients suffering from rheumatoid arthritis. The use of small doses of HYDROCORTONE in conjunction with conservative general measures will permit the safe management of these arthritics for prolonged periods of time. Such a program has been shown to provide moderate to great relief in a very high percentage of patients.[2] In severely handicapped people, HYDROCORTONE plus physical therapy will frequently allow the rehabilitation of arthritics who would not be helped appreciably by either measure alone.[3]

OTHER INDICATIONS: Still's Disease, rheumatoid spondylitis, psoriatic arthritis, traumatic arthritis, osteoarthritis, and bursitis.

SUPPLIED: ORAL—HYDROCORTONE Tablets: 20 mg., bottles of 25, 100, and 500 tablets; 10 mg., bottles of 50, 100, and 500 tablets; 5 mg., bottles of 50 tablets. **INTRASYNOVIAL**—Saline Suspension HYDROCORTONE-T.B.A.: 25 mg./cc., vials of 5 cc. Saline Suspension HYDROCORTONE Acetate: 25 mg./cc., vials of 5 cc.

SHARP & DOHME

PHILADELPHIA 1, PA
DIVISION OF MERCK & CO., INC.

REFERENCES: 1. Boland, E. W. and Headley, N. E., *J.A.M.A.* **148**:981, March 22, 1952. 2. Ward, L. E., Polley, H. F., Slocumb, C. H. and Hench, P. S., *J.A.M.A.* **152**:119, May 9, 1953. 3. Snow, W. B. and Coss, J. A., *N.Y. State J. Med.* **52**:319, Feb. 1, 1952.



Both forms of Baker's Modified Milk—Powder and Liquid—contain all requirements for complete infant nutrition and may be fed interchangeably.

The Powder form is particularly adaptable for feeding prematures, and for use as complemental or supplemental feedings.

For routine infant feeding, the Liquid is generally preferred because of its greater ease of preparation.

Both forms of Baker's Modified Milk are supplied gratis to all hospitals for your use.

Normal Dilutions

20 calories per ounce

Liquid form—1 fl. oz. milk to 1 fl. oz. water

Powder form—1 Tbsp. powder to 2 fl. oz. of water.

*U.S. Public Health Service Milk Code

THE BAKER LABORATORIES, INC.

Milk Products Exclusively for the Medical Profession

Main Office: Cleveland 3, Ohio • *Plant:* East Troy, Wisconsin

Upjohn

Ulcer protection that lasts all night:

Pamine*-Phenobarbital Tablets

BROMIDE

Each FULL-STRENGTH tablet contains:

Phenobarbital ..... 15.0 mg. (¼ gr.)
Methscopolamine bromide ..... 2.5 mg.

Dosage:

One tablet one-half hour before meals, and 1 to 2 tablets at bedtime.

Each HALF-STRENGTH tablet contains:

Phenobarbital ..... 8.0 mg. (⅛ gr.)
Methscopolamine bromide ..... 1.25 mg.

Dosage:

While the dosage and indications are the same as for the full-strength tablets, this tablet allows greater flexibility in regulating the individual dose, and may be employed in less severe gastrointestinal conditions.

Supplied:

Both strengths in bottles of 100 tablets.

*REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF METHSCOPOLAMINE

The Upjohn Company, Kalamazoo, Michigan

One-tube economy **plus** two-tube performance



YOURS with the 200-ma MAXICON® X-ray Unit

This modestly priced single-tube unit brings you fully professional radiographic and fluoroscopic facilities. These include the generous full-length table . . . broad-coverage independent tube stand . . . powerful 200-ma transformer . . . high-power rotating-anode tube. You also get:

Full-wave rectification — Brings you *full* 200-ma power for clear, sharp radiographs. Shorter exposures stop motion even when working with obese patients.

Quality that cuts costs — Professionally scaled components mean economical, dependable service.

Room to grow — Later, should you desire to expand your Maxicon installation, you can add a separate under-table tube.

No need to buy! — If you prefer, enjoy all these advantages on the G-E Maxiservice® rental plan with *no* capital investment. Your G-E x-ray representative will give you full details. Contact him at the address below.

Progress Is Our Most Important Product

GENERAL ELECTRIC

Direct Factory Branches:

LOUISVILLE — 501 West Oak Street **CINCINNATI — 3056 W. McMicken Ave.**

PEN·VEE·Oral*

TABLETS

Penicillin V, Crystalline
(Phenoxymethyl Penicillin)



*Trademark

the totally new penicillin for decisive oral dependability

- Formulated specifically for oral use
- Acid-stable—virtually unaffected by gastric acid
- Alkaline-soluble—optimally absorbed in duodenum
- Certain, high blood levels

Supplied: Tablets, 125 mg. (200,000 units), bottles of 36; 300 mg. (500,000 units), bottles of 12. Also available: Tablets BICILLIN®•VEE, 100 mg. (100,000 units) of benzathine penicillin G and 62.5 mg. (100,000 units) of penicillin V, bottles of 36.

Wyeth®
Philadelphia 1, Pa.

when patients complain of

unexcelled relief in nonspecifi

NEW SIGM

best of the old	Acetylsalicylic acid	325 mg.
potentiated by the best of the new	METICORTEN	0.75 mg.
augmented by	Ascorbic acid	20 mg.
plus	Aluminum hydroxide	75 mg.

METICORTEN (prednisone), new Schering corticosteroid, has three to five times the therapeutic effectiveness, milligram for milligram, of oral cortisone or hydrocortisone. Combined in SIGMAGEN with aspirin and ascorbic acid, it permits unexcelled maintenance of "rheumatic" relief at minimal dosages.

Schering

tiff neck • backache • charleyhorse • rheumatics

lumbago • glass arm • devil's grip • bursitis

tennis elbow • trigger finger • sciatica • neuralgia

heumatic disorders

AGEN
TABLETS

indicated in

muscular rheumatism • mild rheumatoid arthritis • myalgia

mild spondylitis • fibrositis • myositis • subacute gout

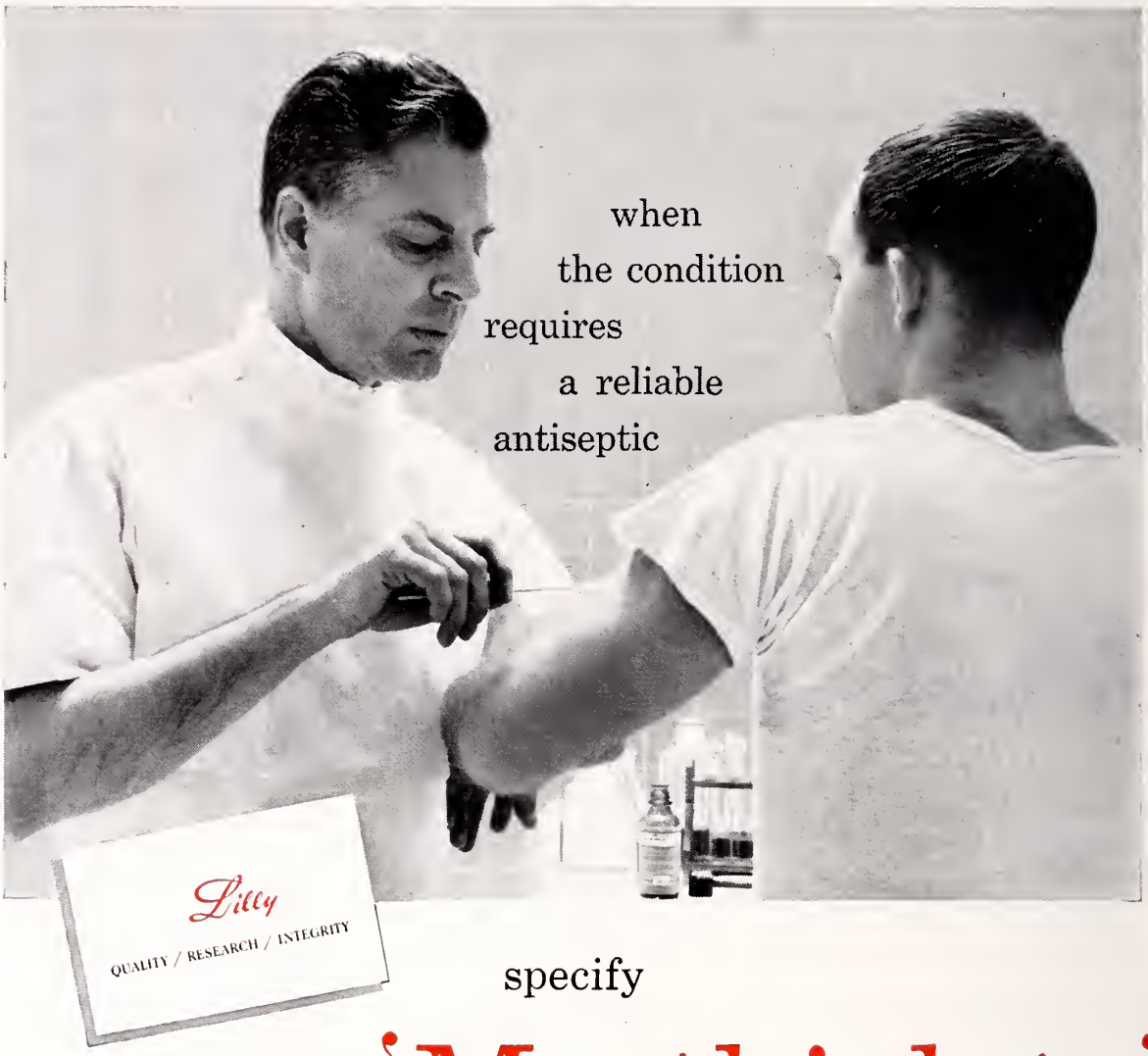
pleurodynia • tenosynovitis • panniculitis • frozen-shoulder

packaging

Bottles of 100 and 1000.

SIGMAGEN,* brand of corticoid-analgesic compound.
METICORTEN,* brand of prednisone.
T.M.





specify

'Merthiolate'

(THIMEROSAL, LILLY)

'Merthiolate' is highly active under virtually all conditions; is relatively nonirritating and nontoxic

'Merthiolate' is germicidal in dilutions up to 1:4,000 in serum media and is relatively nonirritating in the concentrations suggested for use. It also maintains its activity in the presence of soaps. The fact that 'Merthiolate' is used as a bacteriostatic agent in fluids for parenteral administration gives strong evidence of its safety.

660000

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHTY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 FEBRUARY, 1956 NO. 2

Clinical and Metabolic Effects of Prednisone and Prednisolone In Rheumatoid Arthritis*

DAVID H. NEUSTADT, M. D.
ROBERT McCLENDON, M. D.
F. ALBERT OLASH, M. D.
MAURICE BEST, M. D.**
Louisville

This report describes our initial observations on the clinical and metabolic effects of prednisone and predisolone in a series of 17 patients with active rheumatoid arthritis.

Bunim and co-workers[1] first called attention to the therapeutic value of these compounds in a preliminary study of seven patients, who were treated with prednisolone for short periods, varying from twelve days to two and one half months. They indicated from these studies that these drugs had a more potent antirheumatic response than either cortisone or hydrocortisone without producing the undesirable side effects.

Only a limited number of reports on early and short-term investigational studies have been published so far.[1-5].

Owing to the widespread interest that has been aroused concerning the use of these compounds, we are reporting the results of our trials with these agents. A comparison of the structural formulae of prednisone with cortisone, and prednisolone with hydrocortisone is shown in Figure 1.

Clinical Material

Twenty patients with active progressive rheumatoid arthritis were selected from the Arthritis Clinic and in-patient service of the Louisville General Hospital to receive the new steroids. Criteria for the diagnosis of active rheumatoid arthritis was based on that established by the American Rheumatism Association in the "Primer and Handbook for Arthritis Clinics."[6] No patient was accepted in the study group unless the diagnosis was unequivocal rheumatoid arthritis. One case of rheumatoid (or ankylosing) spondylitis is included. Of this original group of 20, 17 patients warrant final analysis. Three patients were eliminated from the study because their clinic attendance was too unreliable for careful follow-up.

Each patient was classified as to stage of severity of the disease, as well as to class of functional impairment.[6]

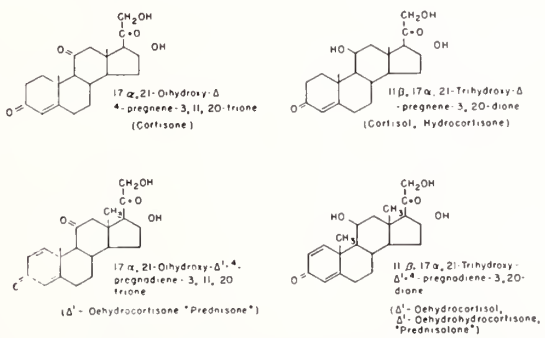


Figure 1—Prednisone is produced by dehydrogenation at positions 1 and 2 of the cortisone nucleus, resulting in the double bond between C-1 and C-2. Prednisolone is produced by a similar change of the hydrocortisone nucleus.

*Presented before the Kentucky-Tennessee Regional Meeting of the American College of Physicians, Louisville, Kentucky, November 5, 1955.

**From the Dept. of Medicine and Arthritis Clinic, University of Louisville School of Medicine and Louisville General Hospital.

Prednisone and Prednisolone used in this investigation was supplied through the courtesy of Med. Dept., Schering Co., Bloomfield, N. J.

In Table 1 is listed the background data in detail on each patient.

In four patients, the disease was classified as stage I (mild); in one, stage II (moderate without deformity); in five, stage III (severe with deformity); and in seven, stage IV (advanced with ankylosis).

The ages of our 17 patients ranged from 23 to 64 years. There were 13 females and four males. The average duration of the disease was 8.8 years, varying from one-half year to 22 years.

Basic management programs had been instituted in all patients selected for treatment. This included the use of salicylates or other simple analgesics in regular and adequate dosage; two patients previously had received phenylbutazone (Butazolidin), four chrysotherapy, and eight cortisone. Five were changed directly from the older steroid to one of the new agents.

Methods

The majority of the patients had been observed for relatively long range periods, either in the hospital or in the outpatient clinic, before initiation of therapy. The minimum period of control observation was one month. The disease was inadequately controlled in every patient before treatment.

To determine the clinical effects, a weekly appraisal was performed on each patient. Evaluation of the patient's progress included the routine assessment of the following subjective factors: (1) Pain, (2) Stiffness, (3) Joint tenderness, (4) Feeling of general well-being, (5) Changes in appetite, sleeping habits, and emotional state and (6) Ability to perform activities and functions of daily living.

Objective evaluation was based on the therapeutic criteria established by the American Rheumatism Association.[6]

Circumferential mensuration of swollen joints, changes in surface temperature and skin color, and measurement of ranges of motion of affected joints were recorded at each examination.

Radiographs of involved joints were repeated when indicated. Temperature, pulse, weight and blood pressure were recorded routinely.

Certain laboratory studies were performed on each patient prior to starting treatment, and were repeated at periodic intervals. These included: (1) Complete

TABLE 1

INDIVIDUAL PATIENT'S CLINICAL BACKGROUND

Case No.	Age & Sex	Duration Arthritis Years	Stage	Class	Previous Therapy	Response to Previous Therapy
1	23F	1½	1	2	Phenylbutazone	Slight pain relief
2	35F	3	1	2	Gold	No response
3	52M	6	4	3	. . . . .	. . . . .
4	46F	13	4	3	Gold, Cortisone	Inadequate and undesirable effects.
5	50F	22	4	4	Cortisone	Congestive heart failure and inadequate
6	43F	5	1	2	. . . . .	. . . . .
7	64F	14	3	3	Cortisone	Inadequate
8	61F	5	4	4	Gold	Inadequate
9	28F	½	1	2	. . . . .	. . . . .
10	54F	5	2	2	Cortisone	Inadequate
11	30F	18	4	3	. . . . .	. . . . .
12	63F	5	3	3	Gold, Cortisone	Poor response
13	42M	6	3	3	. . . . .	. . . . .
14	39F	10	4	3	Cortisone	Hyper-cortisonism
15	59F	9	4	4	Cortisone	Undesirable effects and inadequate
16	59M	8	3	3	Phenylbutazone	Slight pain relief
17(A.S.*)	57M	20	3	3	Cortisone, Radiation	Inadequate

*A. S.: Ankylosing Spondylitis.

blood count, hemoglobin and hematocrit, (2) Erythrocyte sedimentation rate, (3) Total plasma protein and albumin-globulin ratio, (4) Blood glucose concentration and urinalysis for sugar.

Serial determinations of serum total lipid and serum total cholesterol were performed in nine patients. Three baseline determinations were made at two-day intervals prior to beginning therapy. The special interest in the effect of the drugs on the values of cholesterol was evoked by the original report of an elevation of this chemical constituent in patients who received prednisolone.[1]

Since unlike cortisone and hydrocortisone, it has been shown by others that the administration of the new hormones in therapeutic dosage does not produce sodium and water retention or potassium loss,[1,3,7,9] these studies were omitted, except in hospitalized patients.

Upper gastro-intestinal X-ray studies were not done before hormone therapy unless a history suggestive of gastro-intestinal disorder was obtained. In those patients who developed gastrointestinal symptoms while on the steroids, radiographic examination of the gastrointestinal tract was made.

Method of Administration

These two new synthetic steroids were supplied to us as an oral preparation, in the form of a scored tablet containing five mg. of either prednisone or prednisolone.

Initial dosage of 20 to 30 mg. was given daily in four equally divided doses, to be taken after meals and at bedtime. No attempt was made to devise a pre-fixed dosage scheme. Continuation of therapy and adjustments in dosage were dictated by the observers in accord with the response of the patient. In the usual case the drug was reduced stepwise, by 2.5 to 5 mg. decrements, at intervals of four to 10 days until the lowest maintenance dosage that would satisfactorily restrain the disease was established. The maintenance dose varied from case to case, ranging from 10-15 mg. Changes in the progression and activity of the disease often required increases in dosage for short periods. This was most notable in three patients started on treatment in the hospital. While in this "sheltered" environment, it was found a lower maintenance dosage could be employed than that needed by the patients after leaving the hospital.

No dietary or sodium restrictions were employed, unless required by an associated condition, and supplementary potassium salts were not given.

Basic measures, such as salicylates and simple physiotherapeutic modalities were continued. A number of patients also received intra-synovial instillations of compound F to troublesome joints at intervals. This procedure was not discontinued unless found to be no longer necessary, which was the case in many of the patients.

Control observations were carried out by interrupting therapy without the patient's knowledge, by introducing a placebo whose appearance was identical with the new steroids.

Twelve patients were started with prednisone, and five with prednisolone. Patients were changed from one agent to the other at the same dosage level. No appreciable difference in the effects of prednisone and prednisolone was noted. In this presentation the results of administration of both prednisone and prednisolone will be combined.

Results

Clinical response was rapid in almost all patients. Striking subjective improvement usually occurred within 24 hours, and objective improvement was observed within two to seven days, following the institution of therapy.

In Table 2 is shown a summary of response in individual patients observed up to the present. The results are tabulated for each case, correlating the stage of the disease and the duration of treatment in months with the functional class before and after treatment, the sedimentation rate before and after therapy, and the therapeutic grade response.

When placebo tablets were substituted for the active agents after approximately three months of therapy, all except three patients reverted to their pretreatment state in short order. Cases No. seven, nine and seventeen (in the table) have upheld their improvement on continued placebo administration. When treatment with the new analogues was resumed in those patients who faltered, satisfactory response was as rapid as initially.

In Table 3 is displayed a summary of the change in functional status.

There were no patients in functional Class I before treatment. Five patients were in Class II, and of these, four advanced to Class I and one remained in Class II. Of nine patients in

TABLE 2

INDIVIDUAL PATIENT'S RESPONSE TO TREATMENT*

Case No.	Stage of Disease	Duration of Treatments Months	Class Before Treatment	Class After Treatment	E. S. R.† Before Treatment	E. S. R.† After Treatment	Grade Response
1	1	4	2	1	40	14	2
2	1	8	2	1	21	15	2
3	4	8	3	3	47	23	3
4	4	7	3	2	50	50	2
5	4	7	4	2	55	4	2
6	1	6	2	1	38	41	2
7	3	8	3	2	42	37	2
8	4	8	4	3	56	37	3
9	1	6	2	1	50	10	1
10	2	7	2	2	35	25	2
11	4	8	3	2	48	35	2
12	3	8	3	3	46	27	3
13	3	4	3	3	29	46	2
14	4	7	3	3	..	..	3
15	4	8	4	3	26	5	2
16	3	6	3	2	43	18	2
17 A.S.††	4	7	3	2	46	40	2

*According to the criteria of the American Rheumatism Association, Steinbrocker and others, 1949.
†Wintrobe mm/hr.
††A.S.: Ankylosing Spondylitis

TABLE 3

SUMMARY OF CHANGE IN FUNCTIONAL CLASS

Functional Class Before Treatment	Number of Patients	Class After Treatment I	II	III	IV
I	0	0	0	0	0
II	5	4	1	0	0
III	9	0	5	4	0
IV	3	0	1	2	0
Total	17	4	7	6	0

TABLE 4

SUMMARY OF THERAPEUTIC RESPONSE*

Stage of Disease	Number of Patients	Response in Grade I	II	III	IV
I (Early)	4	1	3	0	0
II (Moderate)	1	0	1	0	0
III (Severe)	4	0	3	1	0
IV (Advanced)	8	0	5	3	0
Total	17	1	12	4	0
			70%		

*According to the criteria of the American Rheumatism Association, (Steinbrocker and others, 1949.)

Class II, five advanced to Class II and four stayed in Class III. Of three patients in Class IV (bedridden or confined to a wheelchair) one graduated to Class II and two of Class III.

An additional number of patients improved with regard to their functional capacity with special regard to their ability to accomplish certain activities of daily living, but this was not enough to change their functional class when evaluated according to the established criteria.[6]

A final analysis of therapeutic grade response of the patients, divided into the four stages of rheumatoid arthritis, is shown in Table 4.

Of four patients in Stage I, one obtained a Grade 1 response (complete remission) and three a Grade 2 response (major improvement). One patient in Stage II obtained a Grade 2 response. Four patients were in Stage III; three obtained a Grade 2 response. Of eight patients in Stage IV, five made a Grade 2 response.

Laboratory Results

The erythrocyte sedimentation rate was accelerated in 16 patients before treatment. Nine of these (or 53%) had decreased to normal or near normal levels at the time of analysis. However, earlier in the study period before the maintenance dose was reached, a greater number of patients exhibited significant reductions.

There were no consistent changes in the level of hemoglobin, hematocrit, total red or white blood cell or differential count.

Routine urinalysis for sugar concentration revealed glycosuria at various times in two patients. Fasting blood sugar determinations were essentially unchanged during treatment. Glucose tolerance tests were done in the two patients who spilled sugar in the urine. The curve was modified with respect to a prolonged time in returning to the fasting level, but values did not reach significant hyperglycemic levels.

In 11 patients with reversed albumin-globulin ratios or significant hyperglobulinemia, there was restoration to normal in seven and definite improvement in one.

In the nine patients in whom serial determinations of serum total cholesterol were performed, there was a general trend toward increase in serum cholesterol during the periods of hormonal therapy, but the increase was neither pronounced nor consistent. In two subjects the rise in serum cholesterol was in excess of 20% of the pre-treatment level, but the mean increase for the entire group was only 7.6%. Changes in serum total lipid were similar to those in cholesterol.

Figure 2 depicts graphically the changes in serum cholesterol with varied dosage in one case.

Untoward Effects

The side effects that occurred during prednisone and prednisolone therapy are listed in Table 5.

Physiological effects, such as rounding of the face and hirsutism, were the most frequent. A total of 23 side effects were found in nine patients (53% of the series).

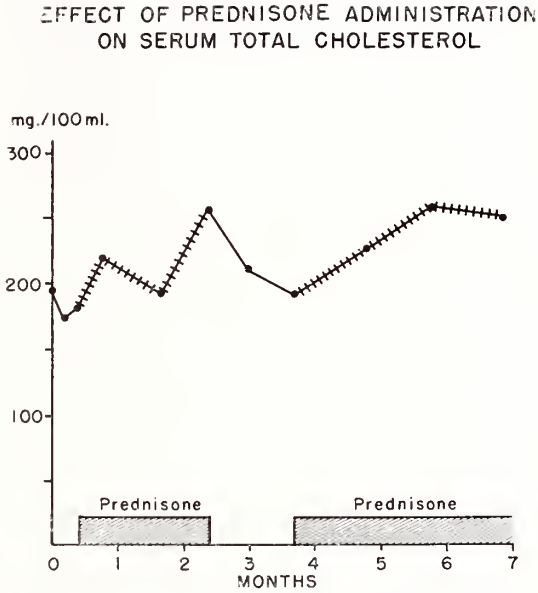


Figure 2—Effect of Prednisone administration on serum cholesterol levels in one case.

TABLE 5

SUMMARY OF UNTOWARD EFFECTS

Side Effects	No. of Patients (53%)
"Moon" Faces	6
Hirsutism	3
Acne	1
Increased appetite, marked	2
Insomnia	1
Elevated Blood Pressure	2
Mental (Personality) change, mild	2
Transient glycosuria	2
Gastrointestinal symptoms (negative x-ray)	2
Gastric ulcer	1
Purpura	1
No discernible undesirable effects	8 (47%)

In only one patient was the reaction a potentially serious complication. This was the development of a gastric ulcer after four months of therapy. The patient was placed on an ulcer regimen and the steroid was continued in the same dosage. Ulcer symptoms abated and healing of the ulcer was followed by serial X-rays. One case of cutaneous purpura and spontaneous ecchymosis occurred which subsided without altering the dosage of the hormones (Figure 3). Therapy was not discontinued in any patient, and reduction in dosage often caused less pronounced changes in adrenal cortical effects.

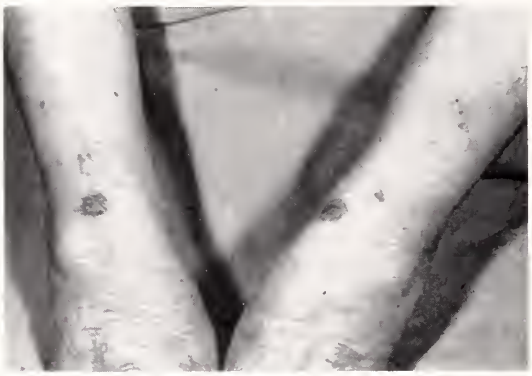


Figure 3—To be noted: Purpuric and ecchymotic lesions on dorsal surface of forearms.

Four patients, who were unable to tolerate the older steroids because of pronounced hypercortisonism with water and sodium retention were able to take the newer drugs with marked lessening of the undesirable effects.

No clinical evidence of fluid retention that could be attributed to the drugs was encountered.

Discussion

Other investigators have reported favorable results with prednisone and prednisolone in patients who either responded inadequately or were unable to tolerate previous steroid therapy owing to the occurrence of troublesome side effects.[1,5,7] In our series of patients, eight had previously been given cortisone without obtaining satisfactory control of the disease due to poor response and/or undesirable side effects. Of these eight, six attained major improvement, and two minor improvement with the new analogues.

The early suggestion that these drugs caused fewer side effects and could be administered without due precaution now appears to have been premature.[1] The incidence of minor adverse reactions with prednisone and prednisolone appears to be equal to that which occur with cortisone and hydrocortisone. Some workers believe that certain major side effects resulting from the new derivatives, such as the diabetogenic properties, the effect on mental changes, and the apparent peptic ulcerative phenomena on the gastro-intestinal tract, are more profound than with the older steroids. One recent report of three patients who developed asymptomatic duodenal ulcers, accidentally discovered by gastro-intestinal X-rays, even suggests the routine use of an antacid in conjunction with prednisone or prednisolone administration[10]. Further observation over prolonged periods is needed for final evaluation of the frequency and type of undesirable effects resulting from these substances.

In our series only one patient obtained a Grade 1 response or complete remission. This patient was a 28 year-old woman whose arthritis was of only six months duration. This observation in only one patient is of dubious significance. However, it is possible that a greater number of patients may have achieved a remission or qualified for a Grade 1 response, if an effort had not been made to reduce medication to the minimum level at which the patient could be controlled.

An additional group of 20 patients with active rheumatoid arthritis was treated for periods ranging from three months to eight months, with an average duration of therapy of five months. Six (or 30%) of this series achieved a Grade 1 response or complete remission; 10 (or 50%) a Grade 2 response or major improvement; and four minor improvement. This closely approximates the results in the study group with the exception that a higher percentage obtained a Grade 1 response or complete remission. It is noteworthy that the initial dosage in these cases ranged from 20 mg. to 40 mg., and the maintenance dosage varied widely from 7.5 mg. to 25 mg. The occurrence of untoward effects closely paralleled that of the clinic series. Two patients had transient glycosuria, and one latent diabetic was discovered. The only alarming side effect was a gastric ulcer which healed with appropriate treatment after prednisone was withdrawn.

Summary

(1) The clinical and certain hematological and metabolic effects produced by the

administration of prednisone and prednisolone for periods varying from four to eight months were observed in a series of 16 patients with active rheumatoid arthritis and in one with ankylosing spondylitis.

(2) Striking anti-rheumatic effect was obtained in 13 cases (or 76%). One patient obtained a complete remission or Grade 1 response and 12 major improvement or Grade 2 response.

(3) Therapy is of a suppressive nature, and when interrupted for control observations with placebo administration, most patients promptly relapsed to their pretreatment state.

(4) No consistent or significant influence on hematocrit, hemoglobin, total red, white or differential count was observed. Abnormal sedimentation rates and reversed albumin-globulin ratios were restored to normal or near normal levels in the majority of patients. Mild interference with glucose utilization was found in two cases. Serial determinations of serum total cholesterol and total lipid revealed a trend toward increase during the periods of therapy.

(5) Nine patients (53%) displayed a total of 23 side effects. Twenty-one were minor in nature and comparable to the adrenal cortical effects resulting from the older steroids. One case of purpura and one of gastric ulcer were observed.

(6) The major advantages of the new steroids are the ability to produce an improved clinical response in some patients who were inadequately controlled on older steroids, and the lack of fluid retention at therapeutic dosage.

(7) No apparent difference in the clinical and metabolic effects of prednisone and prednisolone, given at the same dosage level, was demonstrated.

BIBLIOGRAPHY

1. Bunim, J. J.; Pechet, M. M., and Bollet, A. J.: Studies on metacortandralone and metacortandracin in rheumatoid arthritis. Anti-rheumatic potency, metabolic effects, and hormonal properties, J.A.M.A. 157:311, 1955.

2. Boland, E. W.: Recent advances is rheumatic diseases, California Med. 82: 65, 1955.

3. Dordick, J. R., and Gluck, E. J.: Preliminary clinical trials with metacortandracin in rheumatic diseases. I. Comparative anti-rheumatic potency, metabolic activity and hormonal properties, J.A.M.A. 158:166, 1955.

4. Gray, J. W., and Merrick, E. P.: The clinical evaluation of Meticorten in rheumatoid arthritis and allied conditions. J. Am. Geriatrics Soc. 3:337, 1955.

5. Margolis, H. M.; Barr, J. H. Jr.; Stolzer, B. L. Eisenbeis, C. H., Jr., and Martz, E. W.: Effects of prednisone (Meticorten) on manifestations of rheumatoid arthritis. Report of early clinical observations, J.A.M.A. 158:454, 1955.

6. Steinbrocker, O.; Traeger, C. H., and Batterman, R. C.: Therapeutic Criteria in Rheumatoid Arthritis, J.A.M.A. 140:659, 1949.

7. DeMartini, F.; Boots, R. H.; Snyder, A. I.; Sandson, J., and Ragan, C.: Comparative effects of prednisone and ortisone, J.A.M.A. 158:1505, 1955.

8. Spies, T. D.; Stone, R. E., and Spies, H. A. Jr.: Metacortandracin and delta-1-dehydrocortisone in rheumatoid arthritis, GP 12:73, 1955.

9. Villa, L.; Ballabio, C. B.; Sala, G.: Metacortandracin and 9-Alpha-Fluro Hydrocortisone Acetate in Rheumatic Diseases, Ann. Rheum. Dis. 14:251, 1955.

10. Bollet, A. J.; Black, R., and Bunim, J. J.: Major undesirable side-effects resulting from prednisolone and prednisone, J.A.M.A. 158:459, 1955.

SEASONAL ALLERGY*

MAURICE KAUFMANN, M. D

LLOYD D. MAYER, M. D.

Lexington

There is much more to seasonal allergy than hay fever or rose fever. As a matter of fact, these two entities are not due to either hay or roses per se, but are misnomers in the light of our present knowledge, regarding seasonal allergic rhinitis. For the purpose of this discussion and because "hay fever" remains the most popular designation, it will be used interchangeably with the more correct terminology of "seasonal allergic rhinitis," "pollen allergy," or "pollenosis." These latter terms are more scientifically descriptive and accurate.

Historical Data

Historic literature makes casual reference to seasonal attacks of sneezing occurring at the time roses bloom, but it remained for John Bostock in 1819 to describe this syndrome as "summer cartarrh" and to indicate that it was a definite disease, with a seasonal incidence and a distinct symptomatology.(1) The laity had attached the name of hay fever to this symptom-complex because hay was considered to be its cause and fever was the term used at that time to indicate any type of indisposition, whether it was febrile or afebrile. Elliotson in 1830 observed that one of his patients who had the disease discovered that it occurred only when the flower was in bloom and reasoned that the pollen was a causative agent.(2) Incidentally, Elliotson was the first to describe an instance of dermatitis of the

*Presented before a meeting of the 14th Councilor District.

hands following the handling of the grass flowers. Wyman in this country, in 1872 proved rather conclusively that ragweed pollen was responsible for the disease.[3] He did this by a very simple experiment. He took a bag of ragweed pollen with him to the White Mountains were he was symptom free but upon opening the bag and sniffling the pollen, he was able to reproduce symptoms. In 1873, Blackley published the first of a series of studies which showed by mucous membrane and skin tests that pollen is the cause of hay fever.[4] Unfortunately, much of his work received very little recognition at the time. He was the first to use the skin test which he performed on himself by the scratch method using dry pollen as the antigen at which time an urticarial wheal at the the site of the test was noted. He also advocated the principle that the severity of the disease could be reduced by avoidance and the use of filters. In fact, he even designed a pollen filter for use in the home of a sufferer. Thirty years went by before any attempt was made to try "specific desensitization," and it was not until 1911 that Noon definitely established active immunization or desensitization procedures for the treatment of hay fever by subcutaneous administration of pollen extract.[5] In the following decade many other pioneers in allergy did much basic work which laid the groundwork for our present knowledge concerning the diagnosis and treatment of hay fever.

Pollen

The incidence of seasonal allergy in the general population has been variously estimated at from 2 to 5 per cent, which amounts to four to five million sufferers, with hay fever being the most usual clinical manifestation. As will be shown later, there are many other clinical conditions for which pollen is responsible. Furthermore, pollen allergy or pollenosis, is one of the most common forms of allergy, not only in man, but in other species as well. In order to have a better understanding of pollen allergy one must have some knowledge about the agent which causes the manifestations of pollenosis.

In his chapter on pollen, Tuft says, "This is a cellular structure, corresponding in the plant to the male sperm cell of the animal kingdom, and important in that process of plant fertilization known as pollination. This process consists in the transference of pollen from the male element or stamen to the female element or pistil. Although accomplished in several ways, only those plants whose pollen is transferred by wind or insects are likely to produce hay fever, and of these two groups only the wind-pollinated plants are of clinical importance. An enormous number of wind-pollinated plants exist throughout the world, but comparatively few of these are capable of producing hay fever."[6] Elsewhere, Tuft says, "In order for the pollen of any plant to be of importance in the production of hay fever symptoms, it must satisfy certain requirements which have been set forth arbitrarily by Thommen under the heading of the five postulates:[7]

"1. *The Pollen Must Contain a Specific Excitant of Hay Fever.* Thus, for example, pine pollen is light, abundant and windborne; yet it does not produce hay fever because it does not contain a specific excitant.

2. *The Pollen Must be Wind-borne (Amenophilous).* This explains the reason that insect pollinated plants are not important as causes of hay fever.

3. *The Pollen Must Be Produced in Large Quantities.* This is a characteristic of wind pollinated plants and is essential in the production of hay fever symptoms. The amount produced varies greatly among the different species—thus it has been estimated that each ragweed plant produces 100 pollen granules, whereas June grass produces 50 and English plantain 30. Obviously, even though the same number of plants are present in a particular vicinity, ragweed would produce more pollen than English plantain.

4. *The Pollen Must be Sufficiently Buoyant to be Carried Considerable Distances.* This depends largely on its physical characteristics. Pollens small in size (less than 35 micra), light in weight, spherical in shape and dry in character are found to be of greatest importance in hay fever because these qualities permit them to be blown most readily by the wind.

5. *The Plant Producing the Pollen Must be Widely and Abundantly Distributed.* This fact is significant when it is realized that in many localities numerous species of important hay fever producing plants are found which are of no clinical importance because of insufficient distribution."

There are many other considerations regarding pollenation and pollenosis which are important. The pollen or the patient may be directly or indirectly affected by meteorologic and atmospheric conditions

including wind velocity, the presence, absence or amount of rainfall, humidity, fog and the amount of sunshine. It can readily be deduced from what has been stated that atmospheric pollen concentration varies not only from season to season but even from day to day or from one hour to the next. Recognition of these factors will tend to clarify many clinical facts and variations and give us a better insight on how to combat them. In general, it is well to remember that pollenation is heaviest during the early morning hours and usually reaches its peak about the middle of the particular season.

Pollenation and Other Inhalant Allergy

Generally speaking, the three main groups of allergenic pollen producers in Kentucky are trees, grasses and weeds. Of these three groups, trees account for about 10%; grasses for about 30 to 40%; and, weeds for about 50 to 60% of pollenosis. It should be pointed out that these are arbitrary figures and are subject to changes and modification depending upon the area of the United States in which hay fever sufferers reside.

Based upon clinical observation and atmospheric studies by the use of a standard gravity sampling device, the division into the above three etiologic groupings may lead to faulty etiologic diagnosis, since there are two other groups of inhalants which may play an important role in contributing to, or precipitating seasonal symptoms. These are mold spores and dusts of various kinds, especially house dust. Moreover, the specific antigen which is present in the protein or water-soluble fraction of these allergens is responsible for the production of the respiratory manifestations such as hay fever and pollen asthma. There also is an oil-soluble fraction of pollen which frequently is responsible for the cutaneous and ocular manifestions of seasonal allergy.

Tables I through V will serve as a clinical guide to help determine the relationship between the seasonal allergens and the resulting clinical manifestations. It should be remembered that overlapping occurs and pollenation may be early or late, depending upon variations in geographic, atmospheric and meteorologic conditions.

Diagnosis

There are very few diseases or conditions in medicine in which an exact history is so important for accurate diagnosis and successful management, as in seasonal allergy. If the patient can remember dates or seasons, and if the physician takes the time and makes the effort, the exact etiologic agents can be determined in the majority of cases. Of course, this implies that the inquirer has a knowledge of specific allergens which are active at the time of year the patient has trouble. Often, it is impossible to get a history of dates, seasons, activities and other contributing factors, during the initial visit. If these data are not procured when the patient gives the original history, it

TABLE I

Early Spring (February - April)

Allergens	Common Clinical Manifestations
Tree Pollen	Perennial Allergic Rhinitis
Alder	Seasonal Allergic Rhinitis
Ash	Allergic Conjunctivitis
Birch	Vernal Catarrh
Cedar	Bronchial Asthma
Elm	Allergic Sinusitis
Maple	Atopic Dermatitis (Eczema)
Poplar	Contact Dermatitis
Willow	
Mold Spores	
Alternaria	
Hormodendrum	
House Dust	

TABLE II

Late Spring (April - June)

Allergens	Common Clinical Manifestations
Tree Pollen	
Hickory	Seasonal Allergic Rhinitis
Locust	(Hay Fever)
Oak	Perennial Allergic Rhinitis
Sycamore	Allergic Sinusitis
Walnut	Allergic Conjunctivitis
Grass Pollen	Bronchial Asthma
June (Blue	Vernal Catarrh
Grass)	Atopic Dermatitis
Orchard	Contact Dermatitis
Red Top	Urticaria
Timothy	Angioedema
Dock	Erythema Multiforme
English Plantain	Gastrointestinal Allergy
Mold Spores	
Hormodendrum	
Insect Scales	
(Caddis & May Fly)	
Foods (In Season)	

TABLE III

Mid Summer (July - August 15)

Allergens	Common Clinical Manifestations
Grass Pollen	
English Plantain	Seasonal Allergic Rhinitis
Lamb's Quarters	(Hay Fever)
Sheep Sorrel	Perennial Allergic Rhinitis
Rusts and Smuts	Bronchial Asthma
Mold Spores	Allergic Conjunctivitis
Hormodendrum	Atopic Dermatitis
Alternaria	Solar Sensitivities
Helminthosporium	
Fusarium	
Physical Allergy	

TABLE IV

Early Fall (August 15 - Frost)

Allergens	Common Clinical Manifestations
Ragweed	Seasonal Allergic Rhinitis
Marsh Elder	(Hay Fever)
Pigweed	Perennial Allergic Rhinitis
Cocklebur	Bronchial Asthma
Wormwood	(Pollen Asthma)
Mold Spores	Atopic Dermatitis
Hormodendrum	Allergic Conjunctivitis
Alternaria	Urticaria and Angioedema
Fusarium	Vaginitis
Rusts and Smuts	C. N. S. Manifestations

TABLE V

Late Fall (October)

Allergens	Common Clinical Manifestations
Goldenrod	
Ragweed	
Wormwood (Sage)	Bronchial Asthma
Mold Spores	Atopic Dermatitis
Hormodendrum	Perennial Allergic Rhinitis
Alternaria	
Fusarium	
Helminthosporium	
Rusts and Smuts	
House Dust	
Bacteria	

is wise to ask him to think about it and perhaps on a succeeding visit he may recall certain events which will help confirm or establish the dates of onset and recurrence of symptoms. Because pollenosis is seasonal in its incidence, inquiry should be made about the approximate or exact dates of onset and cessation of symptoms, the period of maximum intensity, the number of years the trouble has been recurring and whether it is always the same time of year. These questions will help elicit information regarding primary and secondary allergens, or for that matter, even rule out pollen as being responsible for the difficulty.

The history should determine other allergic or possible allergic problems. A good allergy history delves into the patient's past and present symptomatology regarding these allergic manifestations. Many of these may have preceded the onset of seasonal allergic rhinitis and will serve as a warning that they may recur in addition to the hay fever. In fact, the coryzal aspects of pollenosis may even disappear, only to be replaced by bronchial asthma, atopic eczema or some other allergic manifestation, thus indicating a change in shock organ or tissue, which is not an infrequent occurrence.

In addition to the above, the history should determine which system is most affected, and which symptoms are the most troublesome. For example, if the nasal symptoms are most prominent, it should be determined whether the itching, sneezing, stuffiness or continuous discharge is most aggravating. The importance of the answer determines, at least partially, the choice of symptomatic medication for relief.

If the patient has had any previous specific treatment or testing, the results of this should be known. If the testing was done five or more years previously, and the symptomatology is now different, or if the symptoms are occurring at another season, then it may be wise to re-survey. Furthermore, inquiry should be made as to the type, amount and results of previous specific hyposensitization. This may give some clue as to what to expect from present treatment. In addition, the patient should be questioned about any reactions, either local or constitutional. If the patient gives a history of frequent reactions from previous hyposensitization therapy, there are two implications. First, the patient may be extremely sensitive and treatment should proceed cautiously, and second, the patient may obtain better results from "low dosage" treatment. The patient also should be asked about medication taken for symptomatic relief, including antihistamines and other sympathomimetic drugs, and those which proved beneficial should again be prescribed and used

until such time when they become ineffectual.

Skin testing should not replace the importance and significance of the history and clinical symptoms. Skin tests have three main purposes, first, to corroborate the history; second, to help determine offenders not elicited from the history; and third, to gain some idea as to the degree of sensitivity, which can be used as a guide in determining the concentration of extract for hyposensitization. It is the patient who should be treated, not the skin tests, and the allergist, as well as the attending physician, should not lose sight of this fact.

The clinical picture of the average hay fever victim is classical. It would be superfluous to dwell upon the description here other than to comment that common symptoms include paroxysmal sneezing, rhinorrhea, nasal stuffiness, conjunctivitis and itching of the nose and palate. The most fearsome and the most common complication of pollenosis is pollen asthma which occurs in about 33% of the cases. The development of seasonal asthma heralds the possibility of future perennial bronchial asthma.

The physical examination should include viewing the nasal mucosa, preferably by using a head mirror and nasal speculum. One can then obtain a much better concept of what is happening to the nasal tissue and underlying pathology. If the nasal mucosa is pale, wet and boggy, one should suspect that the rhinitis is more apt to be chronic in nature and due partially to other allergens in addition to the current seasonal pollens. On the other hand, if the mucosa is injected, glistening and turgid, it probably represents an acute, seasonal exacerbation. The routine examination should go on to include inspection of the eyes, ears, pharynx, and auscultation of the chest. If possible, transillumination of the maxillary and frontal sinuses should be done. The skin should be examined for the presence of coexisting eczema, contact dermatitis or urticaria.

The most significant laboratory finding is the presence of eosinophilia, either locally or in the peripheral blood, which indicates allergy. Eosinophils are generally present in pollenosis and smears should be made from any secretion of the nose, ears, eyes or bronchi and examined for eosinophils. This will often serve to differentiate allergy from infection, though both may coexist.

There are various types of skin and other allergy tests which are employed in the diagnosis of pollenosis. The two most commonly employed cutaneous tests for the protein fraction of the pollen, are the scratch and intradermal techniques. Both have advantages and disadvantages. The former is carried out by a "scratch," using any type of sharp instrument which will excoriate the epidermis, without producing bleeding, then applying the antigen in the dry or glycerinated form to the scratch site. The intradermal method consists of injecting about 0.01 ml of extracted antigen into the epidermis. Both types are read for reaction in 10 to 20 minutes. The scratch test is considered to be safer, whereas the intradermal test seems to produce more positive reactions and can also serve as a titration guide for the concentration of the hyposensitization extract. There are proponents for each method among allergists, in fact, many utilize both techniques. But like any other laboratory procedure, as mentioned before, the correct interpretation is contingent upon the experience and facts gleaned from the history and clinical findings. Whenever the oil fraction of the pollen is suspected as causing symptoms, usually dermatitis or conjunctivitis, then the patch or scratch-patch method of testing is used.

Two other frequently employed methods of testing for pollenosis are the conjunctival or ophthalmic test, and the nasal or sniff test. Both methods utilize the principle of applying the dry pollen directly to the respective mucous membrane and observing for local or general allergic effects. It is not uncommon to obtain good positive reactions to either of these tests after negative cutaneous testing. Nonatopic (non-sensitive) individuals will not react to either of these tests, and nonspecific irritative reactions are rare. Furthermore, in an exquisitely sensitive individual, explosive reactions can occur with either the sniff or eye test just as readily as with the cutaneous method. The uninitiated should never approach any type of allergy or hypersensitivity test without being aware of possible constitutional reactions and taking the necessary precautions to treat such an emergency.

Treatment

The treatment of seasonal allergies or pollenosis is the same as for any allergic condition. Based upon the premise that the specific offender or offenders have been identified by accepted and recog-

nized diagnostic procedures, therapy is based upon three general principles—prophylactic, immunologic and symptomatic.

First, and by far the best, is avoidance of the allergen. This implies removing the patient from the allergen or the allergen from the patient. Contrary to popular impression, this does not always mean that the patient must go to a pollen free climate but it does mean that the patient should try to create a pollen free environment, whenever possible. In fact, other than ragweed, there are few pollens which can be escaped by temporarily going to a different area during the season. Much can be done in one's home to produce an allergy-free environment. The most practical application of this principle is to convert the bedroom into a dust-free, pollen-free setting. For instance, the importance of closed windows or filtered air can readily be appreciated when it is pointed out that the pollenation is heaviest during the early morning hours when most people are in their bedroom and thus inhale a large amount of pollen. Because house dust and mold spores aid and abet the pollen antigen, and because pollen sensitive patients may have an underlying dust and mold sensitivity, these two antigens should receive consideration in the battle against the total hyposensitivity. Moreover, it is only a step further from seasonal problems to perennial allergies. All of these precautions are worthwhile, and the end result will be a room where the patient can retire in the confidence that during the time he is in this room, nothing can possibly aggravate his allergy. Furthermore, the freedom gained from non-exposure to these potent allergens, allows the patient to develop some immunity and thus better withstand allergenic exposure the remainder of the time.

Other than avoidance, hyposensitization or desensitization is the most effective means of controlling pollenosis. The principle of this treatment is to lessen the patient's sensitiveness to the particular pollen or group of aero-allergens which cause his trouble. The most accepted explanation of hyposensitization is that the administration of specific antigenic extract will produce blocking antibodies.[9] If adequate doses of extract are given, enough of these antibodies will be produced to prevent antigen-reagin reaction and thus prevent symptoms from developing. The three methods used in treatment of pollenosis are preseasonal, coseasonal and perennial.

PRESEASONAL: Perhaps this is the oldest and most often used method of treatment for seasonal allergies. It still is in vogue and seems to be preferred by some allergists, but more and more allergists are now advocating perennial treatment. Regarding dosage in preseasonal therapy, the object is to arrive at the largest dose of pollen extract which will give the most protection, without inducing a constitutional reaction, and to do this before the particular season begins. The dose should be reduced 1/3 or 1/2 and given at weekly intervals throughout the season. This is based on the probability that the quantity of naturally occuring allergens plus the extract will overflow the threshold of immunity and precipitate a constitutional reaction. The most important fact is that patients vary tremendously in their sensitiveness and each has a different optimum dose and tolerance, which often can be learned only by trial. When the proper extract in the optimum dosage is used, the majority of patients will have satisfactory results from treatment, although there are a few who apparently cannot build up enough protection from routine preseasonal treatment because of extreme sensitivity to the extract. Before leaving the subject of preseasonal treatment, it should be mentioned that the average commercial package contains fifteen injections with the recommendation that injections be given two to three times a week. This is rather an intensive and occasionally, dangerous program. It is far better to begin preseasonal injections about three to four months in advance. This will allow for time lost or injections missed because of some intercurrent illness; will avoid cumulative effects of antigen, and usually will offer more protection.

CO-SEASONAL: A common misconception, which is contrary to the fact, is that nothing can be done for the hay fever patient after the season begins. If the patient presents himself shortly before or at any time during the season, some relief can be given by resorting to small, frequent doses of extract. This is called "phylactic" or co-seasonal treatment and although it isn't as effective as prophylactic treatment as a rule, some patients are afforded considerable relief.

PERENNIAL: By and large, this is the best method of treatment, at least in our experience. For "pure" pollen cases, perennial treatment consists of keeping the patient on a three to four week injection schedule throughout the year, after the optimum or maximum tolerance dose has

been attained. However, many patients have a multiple sensitivity, not only to the related pollen family members, but to other aero-allergens, and even foods, as well. Failure to recognize this fact will frequently lead to poor results in treatment. With perennial treatment, the patient can gradually be immunized against all offenders for which hyposensitization is commonly employed. This is a safer method and the overall results are better. It is more apt to induce complete protection when continued over a period of years and the actual number of injections are less when compared to repeated preseasonal therapy. Of course, there are certain disadvantages to perennial treatment. Many patients, especially those who have not experienced very severe symptoms, are prone to tire of receiving injections over an extended period of time and will stop treatment before lasting immunity has been obtained. Another group of patients apparently become "saturated" from prolonged treatment and begin to have constitutional reactions from doses they previously tolerated, and though this can readily be corrected, the patient becomes wary of more injections. Another problem arises when the patient misses a few months of treatment and returns with the expectation that treatment can be resumed where it was stopped. Actually, the dose must be cut to half or less and raised back to the previous level by more frequent injections.

Symptomatic treatment represents the third phase in the management of pollenosis. For a while it appeared that the introduction of the antihistamines, and later the corticosteroid hormones, would be the salvation for millions of allergic sufferers. In fact, these medications were hailed by much fanfare, especially in the lay press, which created the false impression that these drugs would end most allergic diseases. No informed physician should rely entirely upon these preparations to treat various and sundry allergies. Even the corticosteroid hormones have failed to resolve many hypersensitivity conditions. In fact, sensitiveness to the hormones and the antihistamines has been observed.

Regardless of the fact that these medications have not proved to be a panacea, they still hold a very high position in the armamentarium of antiallergic agents. The practice of allergy without antihistamines and corticotropic hormones would be comparable to the practice of general medicine without antibiotics. However, it is the judicious use of these preparations in selected cases, which make them helpful additions in the anti-allergic regimen. Today, there are more than thirty different antihistamines from which to choose, although five or six basic formulas comprise the chemical structure of most. The toxic or side-effects of the antihistamines are too well known to discuss them here. Many of the antihistamines are now being combined with ephedrine and ephedrine-like drugs, or are coated, in order to minimize drowsiness. enhance therapeutic results, and to prolong their action. Not infrequently, patients who have been controlled or helped by one of the antihistamines, seem to develop a tolerance to it or the drug seems to lose its effectiveness. This problem can be overcome, in many instances, by rotating to other "basic" antihistamines until another suitable preparation is found.

Most allergists probably regard the use of corticotropin or corticoids for the treatment of pollenosis as an ace in the hole. These potent physiological substances should be reserved for cases which have failed to respond to a fair trial of conventional management. Even in these cases, it has been found that it requires relatively less dosage to ameliorate symptoms than in those cases in which no other therapy has been employed. In our experience, it has been noted that extremely sensitive or refractory pollen treated cases, can ordinarily be satisfactorily relieved by smaller than average dosage of corticosteroids, taken in short courses of five to seven days. Furthermore, there seems to be two periods when the need for one of the corticosteroids, arises. The first is at the height of pollenation which is usually mid-way in the season, and the second period is near the end of the season or post-seasonal. Both of these instances are probably the result of adrenal exhaustion. When and if cortisone, hydro-cortisone, prednisolone or ACTH is considered necessary, the routine precautions and contra-indications must be observed, in order to avoid undue complications from their usage.

Summary and Conclusion

Seasonal allergy results primarily from exposure to airborne substances which act as specific factors in the production of the disease at respective seasons of the year. These allergic diseases include, allergic rhinitis and conjunctivitis, (hay fever), allergic rhinosinusitis ("sinus"), bronchial asthma, urticaria and angioede-

ma, atopic dermatitis, contact dermatitis, and more rarely, vaginitis and gastroenteritis. These diseases are produced for the most part by the various inhalant allergens present in this area. These include tree pollen, mold spores and grass pollen in the spring; chenopods, plantain and mold spores in mid-summer; ragweed, chenopods, amaranths and mold spores in the late summer and fall; and, dust, bacteria and mold spores in the late fall and winter. The diagnosis is made by the clinical history, physical examination, presence of eosinophilia and various diagnostic allergy tests.

Treatment includes the use of prophylactic measures such as avoidance, specific hyposensitization, and symptomatic therapy. Avoidance includes the use of climatotherapy, filtration and environmental control. Specific hyposensitization with an extract of the offending inhalant allergen induces the formation of protective antibodies. Symptomatic therapy comprises the use of epinephrine, ephedrine, antihistamines, corticotropin and corticosteroids, when indicated. These medications should be used as adjuncts during the early stages of hyposensitization and for the relief of particularly severe allergic symptoms, but they should not be used as a replacement for conventional methods of allergy therapy.

BIBLIOGRAPHY

1. Bostock, J.: "Of the Catarrhus Aestivus or Summer Catarrh," Med. Chirurg. Trans., London, 14: 437, 1828.
2. Elliotson, J.: "Clinical Lectures," Lancet 2:370, 1830.
3. Wyman, M.: Autumnal Catarrh, New York, 1876, Hurd and Houghton.
4. Blackley, C. H.: Hay Fever, Its Causes, Treatment, and Effective Prevention, London, 1880, p. 56, Bailliere, Tindall and Cox.
5. Noon, L.: "Prophylactic Inoculation Against Hay Fever," Lancet, 1: 1572, 1911.
6. Tuft, L.: Clinical Allergy, Philadelphia, 1938, p. 185, W. B. Saunders Co.
7. Ibid: p. 188.
8. Kaufmann, M.: Kentucky, Regional Allergy, Springfield, 1955, p. 101, Charles C. Thomas.
9. Cooke, R. A.: Allergy in Theory and Practice, Philadelphia, 1947, p. 63, W. B. Saunders Co.

Surgical Maturation of The Ileostomy*

HART HAGAN, M.D., F.A.C.S. and
WILLIAM H. HAGAN, M.D., F.A.C.S.
Louisville

The treatment of ulcerative colitis has, for many years, been a controversial and difficult problem. The role which surgery should play in the treatment of ulcerative colitis is still widely debated and there is little agreement among those of greatest experience. The surgical treatment of this disease has, of necessity, been inseparably linked with the problems of the iliac stoma. These problems have at times, in some patients, been so severe and so disturbing to internists and surgeons alike, that they have deterred a more aggressive surgical approach to the problem. The problems associated with ileostomy will be reviewed, and what seems to us a logical explanation for some of them will be suggested. With the foregoing in mind, a new technique of ileostomy, suggested by Turnbull and Crile[6,14] and known as "Surgical Maturation of the Ileostomy," will be reviewed and a case illustrating its use will be presented.

Problems of the Ileostomy

What are the problems that have made many reluctant to submit their patients to an ileostomy? [1,3,5,6,10,11,13,15].

The first comprise a group directly related to the technique of bringing the terminal ileum through the abdominal wall and anchoring it. These are prolapse, retraction, fistula formation, stricture, obstruction due to angulation or adhesive bands, gangrene of the ileostomy, etc. The second group of problems pertains to the protection of the skin from the ulcerative effect of ileal content and the problem of finding a simple, inconspicuous, non-odorous appliance that will remain in place and can be easily managed by the patient. Anyone who has seen a patient miserable with a large portion of the abdomen angry, raw and weeping about an improperly managed ileostomy can well understand the aversion to it. The worse this condition becomes, the more difficult it is to get any appliance to function properly. Normal, healthy skin is the first requisite for a satisfactory ileostomy. This is present when the ileostomy is formed. It must be protected and preserved beginning immediately at the time of operation. It is negligent to allow ileal content to come in contact with the skin at any time in the postoperative period.

*Presented at the meeting of the Louisville Surgical Society, May 11, 1955.

The use of a catheter in the ileostomy has been popularized. Regardless of whether this is inserted into the intra-abdominal portion of the bowel or remains in the extra-abdominal segment, the risk of fistula formation is somewhat increased by its presence. It is unnecessary if ileal dysfunction is avoided. With the use of properly applied polyethylene bags and Karaya powder, early skin protection is not difficult and the later application of a permanent bag will not be impeded. Karaya powder, when it comes in contact with moisture, forms a gelatinous, adhesive coating which adheres to the skin and adequately protects it from further moisture.

The third, and most important set of complications, has to do with ileal dysfunction as a result of serosal peritonitis of the exposed ileal segment. We are largely indebted to Turnbull and Crile[6] for an understanding of this mechanism and for the technique which seems to us to be most logical and promising. It has been common experience that in the postoperative period following ileostomy, frequently between the fifth and tenth day, there has been intractable diarrhea and severe disturbances of fluid and electrolyte balance as a result. Rather heroic efforts at intravenous therapy have been necessary to keep pace with the ileostomy discharge. At other times, abdominal cramps, anorexia, distention, visible peristalsis and complete cessation of ileostomy discharge give obvious evidence of the presence of obstruction. This may, at times, be mechanical in nature, but we believe Turnbull[14] has correctly postulated that more frequently all of the symptoms are due to varying degrees of the same process, namely, obstruction, partial or complete, not due to mechanical factors, but to a paralytic ileus of the exposed segment. This results from peritonitis of the serosa of the exposed segment. Others have appreciated this fact and have tried to devise methods of protecting the exposed segment. The suggestion of Black and Thomas[2] that these segments be covered with a skin graft, if this concept is correct, is perfectly logical. Unfortunately, although theoretically feasible in practice, this technique has been disappointing because of late contracture and obstruction.

Maturation of the Ileostomy

The classic ileostomy must progress through certain phases before it begins to function normally. Turnbull refers to this sequence of events as "Maturation of the Ileostomy." Until maturation is complete, varying degrees of dysfunction, that is obstruction, persist. In the course of maturation, the infected serosal surface slowly contracts and pulls the free mucosal border down toward the abdominal skin. This spontaneous eversion of the ileostomy takes place over a period of four to six weeks and is nature's way of covering the exposed and infected serosal surface. Turnbull suggested that the same process be carried out surgically. He first advocated, in 1953, doing this on the seventh day. Crile has more recently been performing surgical maturation immediately at the time of colectomy. This process of surgical maturation has been included with other details of technique in the following description of the ileostomy, which seems to us to minimize the several problems enumerated above.

The Technique of Ileostomy

The first step is the proper selection of the site for the iliac stoma. This is located somewhere in the right lower quadrant. The exact spot is chosen by taking a disc the size of the ring of whatever type bag is to be later used. This is then located so that it falls on flat, normal skin and does not approximate bony prominences, umbilicus or any incision. Commonly this spot will fall at the level of McBurney's point about midway between it and the midline. A circle of skin approximately 2.5 cm. in diameter is removed from the center of this area. The dissection is then coned downward through all layers of the abdominal wall. The fascial defect should admit one finger. If a simple incision or stab wound is made in the fascia, counter incisions at right angles should also be made to avoid a bow-string effect.

The second step is the selection of a level for division of the ileum. A point is taken at least six inches proximal to any gross involvement of the ileum. The bowel is there divided between clamps and a portion submitted to the pathologist for frozen section examination. If there is evidence of inflammatory involvement microscopically, a higher level is chosen and re-examined until one free of disease is found. Residual disease in the remaining ileum is one of the common causes of the failure of surgical therapy.

The third step is delivery without tension of five or more cm. of ileum through the abdominal wall. In order to achieve

this, the ileum and its mesentery must often be freed and relaxing incisions made in the mesentery at right angles to its edge. There is no excuse for leaving the ileostomy under tension to invite later retraction. The division of small bowel mesentery requires an appreciation of the anatomy of its blood supply. Noer[8] has made valuable contributions to knowledge on this subject. He has called attention to the presence of collateral vessels within the wall of small intestine and has demonstrated the effect of division of the mesenteric vessels at varying sites in the arcade. In general, the division should be made in the primary arcade rather than close to the small bowel.

The fourth step is fixation of the ileostomy. Dennis[7] strongly advocates the placing of many silk sutures between ileum and peritoneum. This may be correct, but we have preferred to rely on fixation of about 10 cm. of the mesentery to the peritoneal wall. The portion of ileum above the skin is completely denuded of mesentery and this portion of mesentery is fixed to the fascia. The intramural collateral circulation of the ileum is adequate to maintain considerably more than five cm. of viable bowel after complete denuding of the mesentery.

The fifth and most important step is that of immediate surgical maturation of the ileostomy. Approximately two cm. from the skin level, a circular incision is made about the ileum. This incision is carried through serosa and muscularis layers to the level of the submucosa. A cleavage plane is established between the muscular layers and the submucosa without difficulty. The muscular layers and serosa are then removed distally, leaving a length of viable mucosa and submucosa sufficient to evert and attach to the skin edges. Bleeding points are ligated with 4-0 plain catgut; the mucosal tube is then turned inside out, pulling down over the protruding ileostomy a layer of normal mucosa, the edge of which is sutured to the free skin edge about the ileum.

The final step is immediate skin protection. A polyethylene bag such as is used for deep freeze storage is applied using skin adhesive with a small hole tailored to fit about the ileac stoma. The base of the ileostomy is protected with Karaya powder. No catheters are used in the ileostomy itself; the ileostomy is not dilated at any time. The bag is attached to a tube leading to a drainage bottle. This temporary bag is changed as necessary during the first seven days. By the seventh to the tenth day it should be possible to fit and use a permanent type appliance.

Case Report

This is the case of M. A., a 16 year old boy who, following a summer visit in Mexico in 1953, developed severe diarrhea with ten or more bloody, purulent movements a day, accompanied by severe abdominal cramping and weight loss of twenty pounds. This was first presumed to be amebic dysentery, but many careful stool examinations failed to show evidence of ova or parasites. The next two years were marked with exacerbation and remissions. There was increasing invalidism and x-rays of the colon showed steadily progressive changes. Surgical consultation was requested when the last x-ray examination was reported as showing pseudopolyp formation. He was at this time, in an exacerbation with fever to 102 degrees and five to six loose movements per day despite the fact that he had been on a maintenance dose of ACTH for six months. The practice of prolonged steroid therapy, incidentally, is one with which we are not presently in accord. ACTH and Cortisone are of great value in the preparation of patients for surgery, particularly in the acute fulminating stages of disease. However, they cannot cure the process and their prolonged use entails the hazard of unrecognized perforation of the colon as well as the dangers relating to cardiac, pulmonary and upper gastrointestinal complications.

This patient, after suitable preparation, was treated by a one stage ileostomy and total colectomy. The maximum febrile response in the postoperative period was 99.8 rectally. The pulse rate did not exceed 100 per minute. The maximum ileostomy output was on the fourth day and measured 1200 cc. Full diet was begun on the fourth day, following which the ileostomy discharge became semi-formed. A Torbot bag was applied on the seventh day and did not require reapplication for one week. The patient was discharged on the twelfth postoperative day. In three months he regained 20 pounds weight and has rapidly returned to the activities and vigor of a normal 16 year old male. The presence of the ileostomy has presented no detectable emotional problem. The patient and his family were prepared preoperatively in detail in this regard. This patient has engaged in baseball and swim-



FIGURE 1



FIGURE 2

The appearance of the ileostomy at the end of seven days.



FIGURE 3

A temporary polyethylene bag in place.



FIGURE 4

The permanent appliance in use.

ming without difficulty.

Figures 1 through 4 show the appearance of the ileostomy at the end of one week; the temporary polyethylene bag and the permanent ileostomy appliance in place.

Discussion

The attitude of many toward the ileostomy has been voiced by Bargen[1] of the Department of Medicine at the Mayo Clinic. He states, "In our opinion, success of the surgical treatment of ulcerative colitis is still sharply limited by the problems associated with the ileac stoma. Until these can be better solved, the surgical treatment of this disease should be advised only when complications requiring surgical treatment have developed."

The difficulties encountered in the past may justify such conservatism. On the other hand, many feel that improvements in ileostomy technique and care have lessened this liability, that surgical treatment is often too long delayed, that ulcerative colitis, despite periods of remission and improvement under therapy, is a relentless disease, at present incurable by medical means. Speaking for the Lahey Clinic, Cattell[4] says, "In an early report of our gastroenterologic department, approximately 30% of patients with ulcerative colitis were being submitted to surgery. However, as these patients were followed for longer periods of time, up to 10 or 15 years or more, the percentage of patients requiring surgical intervention definitely increased so that today in our Clinic in a large series, surgical intervention is being used in approximately 50% of patients with ulcerative colitis." Chester Jones[9] avoids too arbitrary a line in

this manner by saying, "It seems to me that an operation should be performed to rehabilitate a patient and make him a useful citizen. When the disease progresses so that a patient is of very little value to himself or his family, it is perfectly obvious to me that he should be operated upon and it is a mistake to try to wait longer hoping that the tide will turn; it will not turn."

By utilizing the technique of ileostomy described, it has seemed to us that the complications of ileostomy were minimized; particularly the period of massive ileal discharge with its attendant problems in skin protection and fluid and electrolyte balance are avoided. The ileostomy, by this technique, is essentially healed, mature and functioning normally by the end of the first week. By avoiding infected serosal surfaces and indwelling tubes, the incidence of fistula formation should also be lessened. The prevention of prolapse will still depend upon adequate fixation of the mesentery or upon sutures placed between ileum and peritoneum. It is not difficult to protect the skin from ileal discharge, beginning immediately at the time of operation and throughout the postoperative period, with materials and appliances now available. The avoidance of skin irritation is essential for the proper functioning of any ileostomy appliance. The anticipation of problems in emotional adjustment to the ileostomy, particularly with regard to the patient's occupation, marriage, athletics and social life can usually be satisfactorily accomplished by an understanding physician and do not require the assistance of a psychiatrist.

Summary

1. At present there is no known medical cure for chronic ulcerative colitis.

2. Proper surgical treatment will result in cure in a large percentage of cases.

3. The several complications associated with ileostomy have deterred many from a more aggressive surgical approach to this problem. These problems are reviewed.

4. A technique of ileostomy which promises to minimize these problems is described.

BIBLIOGRAPHY

1. Bargen, J. A.: The ileac stoma for ulcerative colitis (editorial) Gastroent., 27: 491, 1954.

2. Black, B. M. and J. F. Thomas: Skin-grafted ileac stoma. Proc. Staff Meet. Mayo Clinic, 22: 508, 1947.

3. Brooke, B. N.: The management of an ileostomy-including it's complications; Lancet 2: 102, 1952.

4. Cattell, R. B.: Surgical aspects of chronic ulcerative colitis. Am. J. Surg. 86: 613, 1953.

5. Colcock, B. P.: Technique of ileostomy. Surg. Clinics of North Amer. 31: 775, 1951.

6. Crile, Geo. and R. P. Turnbull: The mechanism and prevention of ileostomy dysfunction. Ann. Surg., 140: 459 1954.

7. Dennis, Clarence: Discussion of paper by Geo. Crile and R. P. Turnbull. Ann. Surg. 140: 459, 1954.

8. Noer, R. J. and J. W. Deer: Revascularization following experimental mesenteric vascular occlusion. Arch. Surg. 58:1, 1949.

9. Jones, C. M.: Medical management of ulcerative colitis. Am. J. Surg. 86: 608, 1953.

10. Lichtenstein, I. L. and S. S. Herzikoff: Recurrent ileostomy prolapse — an old problem. Ann. Surg., 141: 95, 1955.

11. Lyons, A. S. and J. H. Garlock: The complications of ileostomy. Surg., 36: 784, 1954.

12. McKittrick, L. S.: Discussion of symposium of chronic ulcerative colitis. Am. J. Surg. 86: 625, 1953.

13. Rogers, A. G., J. A. Bargen and B. M. Black: Chronic ulcerative colitis: early and late experiences of 124 patients with ileac stoma. Gastroent. 27: 383: 1954.

14. Turnbull, R. B.: Management of the ileostomy. Am. J. Surg., 86: 617, 1953.

15. Warren, R. and L. S. McKittrick: Ileostomy for ulcerative colitis: Technique, complications and management. Surg., Gynec., and Obst., 93: 555, 1951.

Manuscript Memos

Manuscripts should be submitted in duplicate to the Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Mr. J. G. Denhardt, Times-Journal Publishing Company, Bowling Green, Kentucky.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.

Congenital Mucosal Diaphragm of the Pyloric Antrum

W. T. SWARTZ, M.D., and

R. D. SHEPARD, M.D.

Lexington

The distal 2.5 cm. of the stomach adjacent to the pyloric sphincter and known as the pyloric antrum is of extraordinary interest to both the diagnostician and the surgeon for it may be the site of the most baffling abnormalities. It has been stated by Jensen and Rivers (1) that one cannot be certain from nonoperative methods of diagnosis that one is not dealing with a malignancy in 15% of the cases with antral lesions. Although the differential diagnosis of prepyloric lesions usually lies between carcinoma, benign ulcer, antral gastritis and pylorospasm, hypertrophy of normal rugae, benign tumors, lymphosarcoma, syphilis or tuberculosis are frequently considered. (2)

Antral stenosis caused by congenital mucosal diaphragm has been reported but twice in the recent literature. For that reason we feel that the following case warrants presentation.

Case Report

A 55 year old white woman was admitted to the hospital October 12, 1954, complaining of an eight months weight loss of 65 lbs. and progressive persistent vomiting. She had experienced post-cibal nausea and vomiting, the vomitus usually consisting of gastric contents and undigested food. There had been no hematemesis, tarry stools or change in bowel habits aside from intermittent constipation. For many years she had had dyscrasia to fried and fatty food but no jaundice, chills, fever or back pain.

The patient was five years post menopausal. She had 14 children living and well. She had had no previous operations or serious illness. Prior to the present illness she had not been seen by a physician except at the time of her pregnancies.

The physical examination revealed evidence of recent weight loss. Tenderness was present in the antral region on abdominal examination, but no mass, rigidity or rebound was present. The liver, kidneys and spleen were not palpable.

The red blood cell count was 4,500,000; white cell count 9,700; hemoglobin 12.6 gm., 86 per cent. Urinalysis was normal.

X-Ray Examination

Examination of the stomach after a barium meal showed a persistent, constricting defect in the antrum about an inch from the pylorus. (Fig. 1) Initially, this area appeared to be the pylorus until that portion of the antrum distal to its position and the duodenal bulb were filled. The lumen was easily demonstrated at the site of constriction but was somewhat more narrow than that of the pylorus. Normal gastric mucosa was demonstrated between the area of constriction and the base of the bulb. (Fig. 2) The barium was moved through the constriction by normal peristalsis. The deformity remained in all positions and at all angles throughout the examination. No evidence of actual obstruction was seen, the barium passing the partial occlusion with hesitation.

Roentgenographically, the exact nature



FIGURE 1

Persistent constricting defect in antrum demonstrated about one inch proximal to pylorus.

of the constriction was undetermined. From a differential standpoint, it could well have resulted from epigastric adhesions or congenital extrinsic bands, the cicatricial scarring resulting from an old healed gastric ulcer, ectopic smooth muscle in the gastric mucosa, redundancy of the gastric mucosa or perhaps heterotopic pancreatic tissue in the region of the pyloric orifice. An annular form of carcinoma might also have caused such an appearance.

The absence of obstructive signs roentgenographically seemed to be readily explainable, since the opening of this constriction, while slightly smaller than the true pylorus, was large enough to permit liquid to pass.

Because of the persistent symptoms, weight loss and the possibility of a malignancy, the patient was subjected to surgical exploration on October 15, 1954. The liver, gall bladder, large and small bowel and pelvic organs showed no abnormality. The duodenum and pancreas were normal to gross examination. Approximately seven cm. from the pylorus was a uniform, intrinsic constriction 0.5 cm. in width. The overlying serosa was not indented, inflamed or scarred. A longitudinal incision was made on the anterior surface of the stomach, through the region of the narrowing, extending through the pylorus into the first part of the duodenum. The constriction measured 4 mm. in width and appeared as a membrane covered with mucosa, the latter showing no ulceration or edema. This membrane had a central perforation measuring 1 cm. in diameter. The pyloric opening, 7 cm. distal, measured 1.5 cm. The antrum between the membrane and the pylorus was of normal internal diameter. The remainder of the stomach showed no abnormality. A Heineke-Mikulicz pyloroplasty was performed, establishing a lumen that would admit two fingers. The abdomen was closed in layers. The postoperative course was uneventful, the patient being discharged on her 10th day, asymptomatic and on a soft diet. Follow-up examination after six months revealed a weight gain of 25 lbs. and a complete lack of any abdominal symptoms.



FIGURE 2

Normal gastric mucosa demonstrated between this area and the base of the bulb. The lumen of the constriction is somewhat more narrow than that of the pylorus.

Pathological Report

Microscopic sections of a wedge biopsy through the antral band revealed the membrane to be covered by a thin mucosa in which the glands are short, mucus secreting and intestinal in type. The sub-mucosa was a dense, collagenous tissue with relatively little inflammatory reaction and dilated vascular spaces. The muscularis showed essentially normal structure. These findings are consistent with a congenital band in the antral portion of the stomach and correspond with the microscopic description of narrowed congenital stenotic areas encountered elsewhere in the intestinal tract. Gross (3) describes congenital stenotic diaphragms as "narrowed zones showing heaped-up mucosal and sub- mucosal tissues which may be supported by accessory smooth muscle and an irregularly distributed excess of connective tissue in all layers. In those stenoses with only a slight narrowing of the intestine, microscopic examination may show little more than increased fibrous tissue in the submucosa or muscularis."

Discussion

Extensive search of the literature reveals only two similar cases, one, reported by Gross and Durham (4), is of particular interest. This was a 35 year old woman with a history of several years of

upper abdominal fullness and intermittent vomiting partially relieved by liquid diet. X-ray examination, in all positions, demonstrated persistent linear defect with sharp margins 3 cm. below the angularis. At operation, a thin membranous structure 2-3 mm. in thickness was encountered 2 cm. above the pylorus, completely obstructing the antral lumen except for a 4 mm. excentric perforation. This case was relieved by Finney's pyloroplasty. Sams (5) reports the case of an incidental mucosal diaphragm in a case with a gastric ulcer treated by sub-total resection.

It is of interest to consider the fact that this membrane, partially obstructing the lumen of the antrum and producing no real acute symptoms, had no doubt been present some 55 years in our case and 35 years in Gross and Durham's case. The onset of symptoms in the last two years in our case may have been due to the general decrease in gastric tone found with advancing age. The stomach had hypertrophied and forced food through the membrane for many years, finally becoming distended and losing its tone, much like the urinary bladder that hypertrophies and finally decompensates. Certainly it cannot be explained on an inflammatory basis since there was none.

Although the occurence of atresia or stenosis in the esophagus, large or small bowel is well known, most text books on roentgen examination of the gastrointestinal tract and numerous descriptions of the gastric antrum make no mention of this entity in the stomach (6,7,8,9).

Prior to the 5th week of fetal life the intestine is a well defined tube lined with epithelium. Later this epithelium proliferates and the lumen is obliterated as a transitory solid stage is reached in the development of the intestinal tract. Vacuoles appear in the epithelium and a coalescence of these re-establishes the patency of the intestinal tract at about the 12th week of fetal life. An arrest in development may result in either atresia or stenosis. When occurring in the stomach it is usually located at the pylorus and is explained on the same basis as adjacent duodenal occlusion. (10)

Though areas of stenosis in the intestinal tract usually cause symptoms in the first month of life, patients may go for months or even years with only symptoms of occasional vomiting and intermittent abdominal pains treated by dietary changes, anti-spasmodics and laxatives. (11) These stenotic areas have been reported on numerous occasions elsewhere in the intestinal tract of adults, in whom they have presumably been present since birth. (12) Some have produced remarkably few symptoms, others symptoms suggestive of intermittent obstruction from an early age. It is not uncommon to find old people with symptoms of acute pyloric obstruction from duodenal ulcers which undoubtedly have been present for a long time without producing symptoms and which cause almost complete obstruction with a minimum of acute inflammation. The membrane opening in these cases approximates that of the pylorus. Since the gastric contents are usually liquefied when passing through this lumen they meet no more obstruction than that usually encountered at the pylorus.

Summary

A case of congenital antral band is reported and briefly discussed. These lesions are quite infrequent but should be considered in cases presenting antral deformity.

BIBLIOGRAPHY

1. Alexander, F. K.: The Prepyloric Suspect Lesion. Radiology 61: 523-533, October 1953.

2. Shepard, R. D.: The Pyloric Antrum, A Diagnostic Enigma. J. of the Ky. State Med. Assoc., June 1954.

3. Gross, R. E.: The Surgery of Infancy and Childhood. Philadelphia, W. B. Saunders Co., 1953.

4. Gross, K. E., and Durham, M. W.: Pyloric Antral Mucosal Diaphragm. Radiology 61: 368-371, Sept., 1953.

5. Sams, C. F.: Case of Partial Atresia of the Pyloric Antrum Due to Mucosal Diaphragm of Doubtful Origin. Brit. J. Surg. 37: 244-246, October 1949.

6. Templeton, F. E.: X-Ray Examination of the Stomach. Chicago, University of Chicago Press, 1944.

7. Feldman, M.: Clinical Roentgenology of the Digestive Tract. Baltimore, William Wood & Co., 1938.

8. Bockus, H. L.: Gastro-enterology. Philadelphia, W. B. Saunders Co., 1946, Vol. I.

9. Buckstein, J.: The Digestive Tract in Roentgenology. Philadelphia, J. B. Lippincott Co., 1948.

10. Arey, L. B.: Developmental Anatomy. Philadelphia, W. B. Saunders Co., 1941.

11. Reid, D. R. K.: Congenital Obstruction of the Colon in an Adult. Brit. J. Surg. 36: 52-54, July 1948.



PHOTO DATA. CAMERA: 4X5 REFLEX; EXPOSURE: 1/200 SEC. AT F.8 EXISTING LIGHTING.

ACHROMYCI

Hydrochl

Tetracycline HCl *Le*



ely prescribed because of these important advantages:

- apid diffusion and penetration
- rompt control of infection
- egligible side effects
- rue broad-spectrum activity (proved effective gainst a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickttsiae, and certain viruses and protozoa)
- very gram produced in Lederle's *own* laboraories under rigid quality control, and offered *nly* under the Lederle label
- *complete* line of dosage forms

ERLE LABORATORIES DIVISION *American Cyanamid company* PEARL RIVER, NEW YORK

Lederle

. S. PAT. OFF.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1956 Annual Meeting Kentucky State Medical Association

Columbia Auditorium **Louisville, Kentucky** **September 18, 19, 20**

Fill Out and Mail to:

EVERETT L. PIRKEY, M. D., Chairman

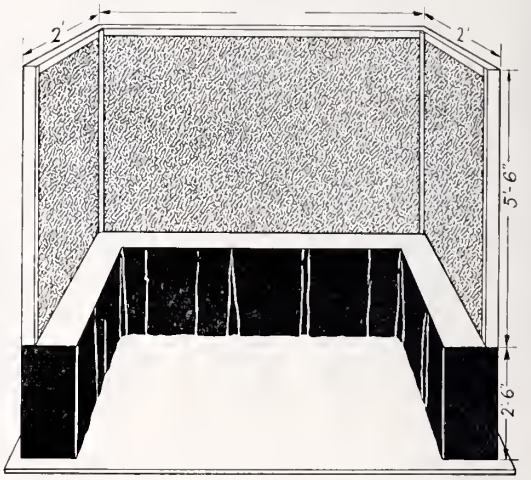
Committee on Scientific Exhibits

Louisville General Hospital,

Louisville 2, Kentucky

(Applications for space should be received before July 1, 1956)

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

The Open Method of Burn Therapy*

JOHN CALVIN WEETER, M.D.

Louisville

In recent years interest in the open method of burn therapy has been stimulated by awareness of the possibilities of large numbers of burn casualties which might result from an atomic bomb attack. Physicians interested in our Civil Defense program are cognizant of the fact that if such an attack should occur, large numbers of burn patients would suddenly constitute our major problem in the treatment of civilian casualties. Attention in recent years to the open or exposure method of immediate local burn therapy, as revived by Wallace, Blocker, and others, has stimulated many physicians to try this method. As with any therapeutic regime in which there is considerable latitude in the method of handling the wounded tissues, some misconceptions have arisen as to the length of time the wound is left exposed, and concerning the degree of attention and care given the wound surface. It is the purpose of this paper to clarify some of the misconceptions which have arisen, and to stimulate further interest in this method of treatment.

Open Treatment—Local Care of the Burned Surface

Initial treatment in the exposure method consists of exposing the injured part to the air. A cradle may be used to keep the bed clothes from touching the patient. Open therapy is continued until the crust peels away, leaving newly healed epithelium in the case of second degree burns, or in third degree burns until the eschar is either mechanically debrided or separates naturally, leaving a granulating surface which will require immediate grafting. Unfortunately, instances of erroneous treatment are occasionally noted where the granulating surfaces are left exposed to the air long after the separation of slough. This misconception concerning the proper time of application of open therapy has caused some criticism and comment as to the efficacy of the open method, and therefore requires clarification. Granulation tissue should never be left exposed. As soon as the eschar has been separated, the advantages of exposure are ended and the surface should be immediately grafted.

Advantages of Open Treatment

The most significant advantage of open treatment noted by those using the method is the prevention of maceration of tissues, with the danger of subsequent infection and loss of newly formed epithelium. In open therapy the crust actually amounts to a heat-sterilized patch of tanned skin which acts as a protective barrier over the viable tissue beneath. This crust barrier remains an effective wound covering until it is cracked, peeled away, or surgically debrided. If there is evidence of fluctuation or pus beneath the crust, the basic principles of incision and drainage should be observed.

Other advantages of open treatment are freedom from cumbersome dressings, and freedom of movement. The patient may be able to move the involved area and frequently he can feed himself and care for himself in a fashion which might be difficult if he were swathed in bulky pressure dressings. Another advantage is that fewer persons may be required to attend such a patient. However, this should not be misconstrued as meaning that less wound care is needed. Open treatment does not mean neglect, for the burned surfaces demand just as much local care as is required with other methods of therapy. Areas of fluctuation and areas of collected pus beneath the crusts must be evacuated, just as an abscess is incised and drained. Cracks in the eschar should be protected against exposure and bleeding of the granulation tissue by the application of strips of fine mesh gauze. These strips should be cut to fit the pattern of the defect, and moistened with saline when applied in order to tack them in place. The crusts, as they begin to separate, may be encouraged to fall off by daily soaking in a tub of water containing a small quantity of ordinary detergent. The exposure method offers an opportunity for daily inspection of the wounds and careful attention to the above mentioned details of wound toilet. Neglect of these details may lead to failure to obtain the maximum benefit from open therapy, and thus give disappointing results.

*This article presents, with added comments, a summary of the text of the author's film, "The Open Method of Burn Therapy" which was shown at the annual meeting of the Kentucky State Medical Association on September 21, 1954.

Contraindications

Open therapy is not easily applied to circular deep burns in which a large burned area must rest on the bed surface. Pressure dressings are preferred for these burns since they cannot be easily exposed. Burns of the hands are likewise best treated by pressure dressings. The hand is dressed in a position of function, using fine mesh gauze next to the wounded surface, and wrapping the fingers separately, carefully avoiding pressure on the digital nerves and vessels. A bulky padding of gauze pads or fluffs, together with elastic bandages for obtaining mild pressure, completes the dressing. Pressure dressing should be changed every few days, and under no condition be allowed to remain in place long enough to pool pus and prevent free drainage.

Early Excision of Slough

Early excision of slough and early grafting speed rehabilitation. In localized areas of obvious third degree burn, the slough should be excised as soon as possible—possibly during the second week after injury. The surface should then be grafted immediately. In burns of the hands and over other areas where tendons and other important structures are close to the surface, and in cases of extensive burns, the natural separation of slough may be preferable. In hand burns, this avoids the danger of excising tendon sheaths, thus destroying the gliding surface of the protective covering. If, when natural separation of slough occurs, tendons are exposed, they should be covered with skin-and-fat flaps so that a good substitute for the gliding mechanism is offered. Split grafts are not satisfactory coverings for exposed tendons. In extensive burns where there is a question of insufficient donor surface for grafting, natural separation of slough may be advisable. This will conserve all areas of possible second degree burn where healing will occur spontaneously, thereby minimizing the total surface area needed for cutting grafts.

In preparation for grafting, the open wound is covered with fine mesh gauze to avoid tearing of granulations and bleeding at the next change of dressing two days later. The author prefers gauze impregnated with Furacin because of its inhibiting effect on the common bacterial skin contaminants. The preferred grade of gauze is 44x40 mesh which is left in the roll form for ease in handling. If the surface is clean at the time for dressing two days after debridement, the area is resurfaced with grafts immediately. This two-day interval permits the operator to debride any necrotic areas which may have remained unnoticed at the time of the first debridement.

A Plea For Early Grafting—The Golden Period

During the "Golden Period"—the few days between separation of slough and the onset of gross surface infection—grafts take easily. Delay in grafting beyond this golden period means less chance for a good take, and gives the organisms present in the open wound a chance to gain foothold. Furthermore, delay in grafting means loss of blood and protein, and begets general debilitation. Failure to get adequate take may be due to lack of perfect immobilization, hematoma beneath the graft, or severe infection with copious quantities of pus lifting the graft from its recipient bed. In extensive burns, the grafts are cut as thin as possible to permit the taking of a second graft from the same donor area, if needed. Thicker grafts are preferred to resurface the hands, joints, neck and other areas of possible contracture. If a second session of grafting is needed to complete the coverage of small areas of nontake, small stamps backed with gauze impregnated with rubber cement are useful; they are easily cut to the exact pattern of defect, easily handled, and maintain the graft at ordinary skin tension, thus obviating curling and shrinking.

Homografts and Skin Banks

Homografts may be used successfully as a temporary covering in extensive burns, especially if the condition of the patient does not permit the extensive cutting of grafts early in the course. As a temporary covering, skin from another donor will remain viable in many cases for about six weeks. Their use may permit the physician to build the patient up generally, combat anemia and protein loss, and permit healing of donor areas before a second graft is cut from the same donor site. In some cases, checkerboard application of homografts and autogenous skin at the same time is useful, and the gradual replacement of epithelium developing from the autogenous stamps as the homografts disappear may allay the necessity for further grafting. Skin for homografts may be successfully stored for as long as two months, according to Brown, et al. A well

stocked skin bank should be maintained in medical centers where many burns are handled.

Donor-Site Care

The proper care of the donor site is important, especially if several grafts must be cut from the same donor area. Prompt healing of donor areas depends upon the absence of infection. The basic principle of open treatment is conducive to maintaining a clean dry wound. An effective method of the donor-site dressing is the application of Furacin impregnated fine mesh gauze placed next to the open wound. This is followed by the application of several layers of open gauze pads. A layer of sterile wax paper separates this basal layer from an outer absorbent pressure dressing.

Two days after the graft is cut, the outer absorbent pressure dressing is removed together with the wax paper which easily peels away from the lowermost layer. The basal layers are then permitted to remain in place, and are exposed to the air to dry. After drying, the basal dressing appears as a thin cast-like shell which will peel away as healing by epithelialization occurs beneath. This shell-like dressing should be permitted to peel away by itself and should not be stripped away by the surgeon because of the danger of removing the new thin epithelium.

Physiotherapy

Physiotherapy is a valuable adjunct in the treatment of severe burns and should be used to the fullest extent. Active and passive exercises are started as soon as the wounds are healed. The patient is also encouraged to exercise by himself throughout the day. Elastic bandages are always worn when the legs are in a dependent position, or when the patient is beginning to walk, to minimize edema and to obviate the danger of forming small blisters beneath the recently grafted surface. The use of elastic bandages is continued until the tendency for edema or blistering no longer persists. No case is considered completed until the patient has received maximum benefit from the physiotherapist. The patient is observed at monthly follow-up examinations over a period of several years to check on the development of contractures as the thin grafts shrink. If such contractures develop, additional procedures such as Z-plasty and relaxing incisions with grafting may be indicated. Our final aim through physiotherapy, plastic procedures and a wide-range rehabilitation program is the restoration to normal as quickly as possible.

REFERENCES

1. On Burns: Edited by Womock,. et. al. Charles C. Thomas, Springfield. IU 1953.

2. Pediatric Care of Burned Children. A. H. Herd, M. D. Pl & Recon Surg. 12: 26 October 1953.

3. A Clinical Study of the Use of Skin Homografts for Burns. Douglas Jackson, M. D. British Journal of Plastic Surgery 7: 26 April 1954.

4. Late Treatment of Severe Extensive Burns. T. G. Blocher, Jr., et. al. Southern Medical Journal 47: 371 April 1954.

5. Occlusive Dressing versus Exposure Method in Treatment of Thermal Burns. Hamilton Baxter, et. al. The Canadian Med. Association Journal 69: 97 1953.

Management of the Unconscious Patient

THOMAS M. MARSHALL, M. D.

Louisville

The unconscious patient presents an emergency problem of great importance. Speed in making the diagnosis and rapid initiation of treatment may often mean the difference between life and death. This can be a complex task calling for a broad fund of medical knowledge and sheer persistence. The growing incidence of coma as a presenting finding can be attributed to the greater number of more severe automobile accidents, the increase in the over-indulgence in alcohol and sedatives, suicide attempts and the progressive aging of our population.

First Aid Measures

The importance of the adequate care and the proper understanding of unconscious patients need not be emphasized, for the helplessness of their situation is obvious. The establishment and maintenance of an adequate airway takes precedence over all other problems. All too often the comatose patient is in the supine position when found. This position provides conditions extremely unfavorable to proper ventilation. Nasal and oral secretions, vomitus, blood and a relaxed tongue can readily gravitate into the hypopharynx. This obstruction can easily be prevented by placing the patient on his side or in the Schaefer resuscitation posture. If this is not adequate, a small airway may be introduced. Accumulations

of saliva and mucus should be aspirated from the airway with a small rubber catheter as frequently as necessary. Elevation of the foot of the bed is helpful in keeping the respiratory passage free. In the presence of fractured jaws or trauma leading to swelling and edema of the pharynx and buccal cavities, tracheotomy is indicated. If there is evidence of respiratory embarrassment or if the impending asphyxic state is not due to obstruction but to embarrassment of the respiratory center, artificial respiration and oxygen therapy must be promptly instituted. A face mask is best for this. A mixture of ninety-five percent oxygen and five percent carbon dioxide is preferable to pure oxygen. The carbon dioxide improves the cerebral blood flow. Oxygen therapy is regarded as beneficial in any head injury case, for edema and congestion of the brain inhibit oxygen delivery, leading to more edema and anoxia, thus initiating a vicious cycle. Oxygen therapy may therefore assist in reducing intracranial pressure or at least aid in preventing its further increase. After the establishment of an adequate airway, the control of hemorrhage and the treatment of shock are of prime importance. No elaboration of these first aid measures is needed here except to emphasize that narcotics are not desirable in the presence of coma.

Etiology

An accurate history provided by a member of the patient's family, a friend, the police or an onlooker will often make the diagnosis simple. A story of injury, previous strokes, hypertension, suicide attempts, drug or alcoholic ingestion, recent infection, headaches and vomiting, convulsions, known diabetes or pregnancy often provides the necessary background for diagnosis. The place where the patient is found often provides valuable information.

The etiology of unconsciousness encompasses almost the entire field of medicine. However, in an effort to make them more easily recalled the agents capable of producing coma fall into a few broad categories, the first letters of which form the word COMA-PIC (coma picture). [1].The C stands for cerebral factors; O for opium and other drugs, chemicals and metallic toxins; M for metabolic factors; A for anemic factors; P for psychogenic disturbances; I for infectious agents and C for cardiovascular factors. The cerebral factors include trauma, vascular accidents (thrombosis, hemorrhage and embolism), tumors, degenerative diseases and post-convulsive stupor. Opium in its numerous derivatives represents the drug intoxications. Other commonly encountered agents include alcohol, barbiturates, bromides, carbon monoxide and lead. Alcoholism is a factor in almost three out of five cases. Metabolic factors include diabetes mellitus, hypoglycemia, hypothyroidism, heat exhaustion, sun stroke, uremia, toxemia of pregnancy, alkalosis, dehydration, Addison's disease and cholemia. These factors constitute about seven percent of the cases. Anemic factors include hemorrhages, the anemias and the leukemias. Psychogenic disturbances include malingering, psychoneuroses and psychoses. The infectious agents include pneumonia, meningitis, influenza, tetanus and the familiar exanthemata. These make up about four percent of the cases. Cardiovascular factors include coronary occlusions, hypertensive encephalopathy, Stokes-Adams syndrome, hypersensitive carotid sinus, postural hypotension and cardiac arrest.

Physical Examination

The physical examination is the most important basis of a diagnosis in the absence of a history. The points of special help in the differential diagnosis are the following:

GENERAL APPEARANCE: Evidence of trauma should be sought for carefully. Contusions or lacerations of the scalp with blood or cerebrospinal fluid exuding from the ears, nose or mouth suggest cerebral trauma. However, the presence or absence of obvious scalp or skull injury has little or no bearing on the degree of injury to the brain. The position of the limbs may suggest trauma or fracture. Convulsive movements of the extremities suggest epilepsy, brain tumor, hypoglycemic shock or eclampsia. A bitten tongue usually indicates epilepsy. The color of the skin, mucous membranes and nailbeds should be noted carefully. Pallor suggests hemorrhage or cardiac syncope. A flushed face is found in the alcoholic, in early diabetic acidosis and occasionally in instances of intracerebral hemorrhage. Cyanosis is seen in severe head injuries, convulsive seizures, marked diabetic acidosis, pneumonia and pulmonary edema. The cherry red color of the patient with carbon monoxide poisoning is characteristic. A cold clammy skin suggests shock due to massive hemorrhage or a perforated viscus, myocardial or pulmonary infarction, morphine poisoning or hyperinsulinism. Bi-

lateral dependent edema intimates cardiac, renal or hepatic insufficiency. Unilateral edema suggests cerebral embolism arising from thrombo-phlebitis or phlebothrombosis. Petechial hemorrhages suggest cerebral embolism or meningococcemia. A powdery feeling of the skin may be found in uremic patients. Pale brown pigmentation of the skin and buccal mucous membranes intimate Addison's disease.

Odors: Odors from the patient or his immediate environment may be helpful in the diagnosis. The characteristic aromas of coal gas, cyanide ("bitter almonds") or phenol ("antiseptic") may be noted. The sweet and fruity acetone breath in diabetic acidosis is fairly characteristic and an ammoniacal breath odor is present in the uremic patient. The unmistakable odor of whiskey from the alcoholic should not curtail search for possible head injury or other causes of coma.

Pulse: A rapid, full, bounding pulse is found in high fever and usually in disease associated with hypertension. A slow, full, bounding pulse suggests increased intracranial pressure as a result of trauma, hemorrhage or tumor. A slow, weak pulse is found in patients whose coma is the result of morphine poisoning, freezing or the Stokes-Adams syndrome. A rapid, thready pulse is found in cases of shock and an irregular pulse directs attention to the heart and the cardiac arrhythmias with their distinctive patterns.

Respiration: Loud and stentorous breathing occurs in patients with apoplexy. Slow respiration suggests morphine poisoning or freezing. The Cheyne-Stokes type is observed in the stages of decompensated cardiovascular disease, uremia, heat stroke and increased intracranial pressure. The air hunger type of breathing is seen in diabetic acidosis. Rapid respiration occurs in patients with fevers or infectious diseases and in pulmonary edema and chronic pulmonary disease.

Blood Pressure and Temperature: An elevated blood pressure suggests cerebral hemorrhage although it must be remembered that the blood pressure frequently falls before or during such an occurrence. A wide pulse pressure may suggest increased intracranial pressure. The temperature is of very little value in the differential diagnosis of unconsciousness but is usually elevated in a comatose patient.

Eyes: A careful inspection of the eyes, followed by funduscopic examination is usually very informative. The eyeballs are soft to palpation in diabetic acidosis. If the eyes are turned to one side (conjugate deviation) an intracranial process is suggested, frequently on the side to which the eyes are turned. Unequal pupils intimate a unilateral intracranial lesion. A gross estimate of the depth of coma may be made from the response of the pupils to strong light. If the coma is deep, the pupils may fail to react to light. Absent corneal reflexes also indicate that the coma is deep. Dilated pupils occur in barbiturate poisoning and alcoholism. Constricted or pinpointed pupils are seen after morphine and in cases with hemorrhage into the pons. The pupils tend to be abnormal in the majority of cases of coma, no matter what the cause, and there is no definite rule as to what kind of abnormality will be present in any particular case. A unilateral exophthalmus is seen in cavernous sinus thrombosis and traumatic arteriovenous fistulas. Pulsation of the eye is often noted in the latter. A unilateral ptosis, dilated fixed pupil and lateral deviation of the eye suggest intracranial aneurysm of the internal carotid artery. Auscultation may reveal a bruit. Funduscopic examination may show papilledema, which is due to the increased intracranial pressure resulting from an expanding intracranial lesion or hypertensive encephalopathy. Flame hemorrhages and white patches of exudate in the retina indicate hypertension or kidney disease and suggest uremia as the cause of the coma. "Ball hemorrhages" or punctate hemorrhages and exudates are characteristic of diabetic retinitis. Frequently, the inequality of the palpebral fissures suggest a paresis of one side. If the eyelid is raised on the weak side, it returns slowly to cover the eyeball. Resistance to raising the eyelids occurs in patients with hysteria.

Mouth and Face: Drooping of one corner of the mouth or incomplete closure of the lids of one eye is evidence of facial paralysis. This can be confirmed if the patient is not too deep in coma by marked pressure behind the angles of the jaw on either side. This will produce a wincing motion which will confirm the suspicion of facial weakness. Burns of the lips or mouth are present in corrosive poisons. Lacerations or scarring of the tongue indicate epilepsy. A blue line on the gums is usually pathognomonic of heavy metal poisoning, most often lead or bismuth.

Neck and Extremities: Stiffness of the neck is usually indicative of meningeal

irritation from either an infectious process or intracranial bleeding. The possibility of cervical spine injury in traumatic cases must not be overlooked. It is possible to detect differences in the tone of the paralyzed and non-paralyzed extremities even in coma. If there is any voluntary power remaining in an upper extremity, an unconscious patient will most often not allow his hand to be dropped on his face. A paralyzed lower extremity will be everted. If the patient is lying on his back the knee will drop outward when the extremity is flexed at the hip and at the knee if it is paralyzed. A unilateral response to marked painful stimulus, unilateral hyperactive or hypoactive tendon reflexes or unilateral Babinskis are characteristic of a unilateral intracranial lesion. Reflexes vary with the depth of coma regardless of the cause. If the patient is in deep coma, the tendon reflexes may be completely absent.

TRUNK: The heart and lungs should be checked for organic disease. The arrhythmias and murmurs of cardiac disease suggest the possibility of a vegetative endocarditis producing cerebral embolism. Rales at the pulmonary bases may indicate pulmonary edema with coronary thrombosis or cardiac failure. Rigidity of the abdomen is found in instances of ruptured viscus, ectopic pregnancy and peritonitis. Enlargement of the uterus and other findings of pregnancy plus a history of convulsions and vomiting suggest eclamptic coma.

Laboratory Examination

Less than twenty-five percent of cases of coma will need such aids as laboratory tests for exact diagnosis. The simpler and more important exams should be done first. A urinalysis of a catheterized specimen and a complete blood count and hematocrit determination can be done with relative dispatch and reveal much information. A blood culture may be done at the same time when indicated. Blood chemistry is revealing in obscure cases. Electrocardiography is helpful in cases of suspected cardiovascular disturbances but it is rarely an emergency procedure. A lumbar puncture is usually of vital help in cases still undiagnosed after the history and physical. It determines whether the central nervous system is involved and helps differentiate infections, hemorrhages and certain neoplasms. The clarity and color of the spinal fluid should be noted and its pressure determined with a water manometer. The rate of flow from the needle is not a reliable index of the pressure and the manometer reading is only reliable when the patient is quiet and relaxed. The Queckenstedt test is contra-indicated. This test is frequently misused. It should be utilized only in cases of spinal cord disturbance and in rare instances of suspected lateral sinus thrombosis. It has no place in the treatment or diagnosis of coma. A total of 12cc of fluid should be withdrawn slowly in 4cc fractions and collected in three separate tubes. Such a procedure is helpful in differentiating between a traumatic tap and subarachnoid bleeding. The fluid should be sent for a cell count, total protein and Kahn or Wasserman. If the cell count is over ten, a smear and culture should be done. Sugar and chloride determinations should be done on only those fluids that suggest infection and then are of only limited value. Gastric lavage should be done for all poisonings and severe alcoholics. X-rays of the skull should be taken routinely upon admission to the hospital unless the patient is in shock. These x-rays should be examined carefully for evidences of skull fracture, atrophy or enlargement of the sella turcica, erosion or thickening of the skull, pineal displacement and abnormal calcifications. Fracture across the course of the middle meningeal vessels is present in about eighty percent of cases of epidural hematoma. The pineal is calcified in sixty percent of adults over twenty years of age and its displacement occurs in forty percent of patients with verified intracranial tumors. About eight percent of intracranial tumors contain calcification visible on an x-ray examination. X-rays of other parts of the body may be helpful in establishing systemic illnesses causing coma.

Therapy

Appropriate therapy will usually suggest itself when a working diagnosis has been reached but frequently a prolonged period of continued observation and investigation is necessary. During this time, various conservative measures should be instituted. The blood pressure, pulse, respiratory rate and temperature should be recorded at intervals. The frequency of such observations depends on the tendencies of the vital signs to change. The unconscious patient is incontinent of urine and feces. Urinary incontinence and retention can be controlled by the use of an indwelling catheter which should be irrigated at least two or three times a day. The extreme restlessness of many patients may be traced to a full bladder and the

passing of a catheter solves the problem. An accurate check of the daily urinary output should be kept. Enemas are used to control the bowels but it is important to carry out a digital examination every two or three days to determine if a fecal impaction has developed.

The restless unconscious patient should never be restrained to the bed as this frequently increases the thrashing about. It is helpful to have some member of the family or a friend present to gently restrain them and it goes without saying, of course, that they should be in a bed with side rails. Frequently they pull at their catheter, dressings and other apparatus and this can be prevented by taping the hands closed over a roll of gauze. The thrashing about of some patients is definitely detrimental to their well being and progress. Such activity increases the oxygen demand, utilizes their store of energy needlessly and subjects them to the danger of additional trauma. Sedation is indicated for these patients. The use of morphine is contraindicated. It depresses an already disturbed respiratory center and hides the true state of consciousness. The barbiturates, bromides, chloral hydrate and paraldehyde are better suited for sedation in such cases. Paraldehyde is particularly useful because of its wide margin of safety. The dosage is whatever amount is needed to quiet the patient and it may be given rectally, orally or intramuscularly. If restlessness persists despite the use of these measures in a case of head injury, spinal puncture on the second, third or fourth day after injury may be advisable. Removal of decomposed blood, which is irritating, from the subarachnoid spaces often helps considerably in quieting such a patient.

Nutrition and Nursing

The maintenance of nutrition is an important part of the care of the unconscious patient especially when the unconscious state is prolonged. They should not be carried for more than forty-eight hours on parenterally administered fluids. If the patient is unable to swallow fluids administered with an Asepto syringe with a rubber tip, a plastic Levin tube should be passed through the nose into the stomach. A high vitamin, high caloric mixture can then be given. A minimum of 1500 calories should be given daily during the unconscious period. It may be necessary during the first two or three days of tube feeding to give only small amounts of a rich mixture supplemented by glucose water to avoid vomiting.

The mouth of the unconscious patient demands meticulous and regular care as it is kept open for hours on end. The mucous membranes dry and frequently a parotitis develops. Every three or four hours the mouth should be swabbed with lemon juice in glycerin water on gauze over the index finger. A moistened gauze compress laid over the nose and mouth may help prevent drying of the buccal membranes. Crustations rapidly develop on the eyelids and these should be cleansed as necessary. The body temperature should be kept below 103 degrees if possible with the use of an oxygen tent, alcohol sponge baths, tap water enemas and large doses (30 to 50 grains) of aspirin every two or three hours. The patient should be turned from side to side every three to four hours and a careful check on the skin should be made with each turning. Those responsible for the nursing care should be warned of the hazards to which the skin of the comatose patient is subject. There is no case in which nursing care, with unfailing vigilance and attention to details and maintenance of accurate clinical records is more important than in the unconscious patient. The patient is continually changing. He is never twice the same.

Surgical Risk

The unconscious patient is a poor surgical risk and for that reason, surgery should be deferred until a tenable diagnosis is made. Unfortunately, owing to progressive deterioration of the patient's condition, the surgeon's hand is often forced and the risks of surgery must be taken. In such cases, exploratory operations should be planned in terms of the best available diagnostic indications and carried out as expediously as possible under local or light anesthesia.

Summary

1. The unconscious patient is an emergency. First aid measures are briefly discussed.

2. The etiology of the unconscious state is considered in some detail. The "COMA-PIC" is delineated.

3. Important diagnostic criteria, along with their interpretation, are listed. The usefulness of laboratory work is evaluated.

4. Treatment is outlined and the importance of good nursing care is emphasized.

REFERENCES

1. Meyers, Russell and Meyers, Mary E.: Managing the Comatose Patient, G. P., 4: November 4, 45, 1951.

CASE DISCUSSIONS

THE UNIVERSITY OF LOUISVILLE HOSPITALS
FROM THE CHILDREN'S HOSPITAL*

History

This seven year old white male was admitted to the Pediatric Service on August 2, 1954 with the chief complaint of "sores in his mouth."

The patient had been perfectly well until July 30, 1954 when he developed a fever and complained of pain in his mouth when eating. The symptoms progressed, the child refused oral intake and the local application of prescribed gentian violet gave no relief. He became listless and vomited occasionally. August 1, 1954 his physician administered 0.6 grams of Neo-arsphenamine intravenously. The vomiting became intractable and persisted until hospital admission.

Inquiry revealed that the two and a half year old sister had developed a sore mouth on July 27, 1954 and was admitted to another hospital July 30, 1954. She expired shortly after receiving her second dose of intravenous Neo-arsphenamine. Two male siblings, aged four and nine years, respectively, developed similar complaints of lesser severity concomitantly with our patient. The remainder of the history was non-contributory.

Physical Examination

The physical examination at the time of admission revealed a pale, lethargic, dehydrated white male child. He was vomiting repeatedly and appeared gravely ill. The severe dehydration was accompanied by sunken eyes and acetone odor to the breath. No skin rash was apparent. The tongue, gums and buccal surfaces had innumerable superficial yellow-white ulcers ranging from two to five mm. in diameter. A surrounding zone of edema and erythema was noted. The ulcerative lesions extended onto the tonsils and posterior pharynx. The gums were hemorrhagic and hypertrophied. They appeared nearly to cover the teeth. The anterior cervical lymph nodes were markedly enlarged and very tender. The remainder of the physical examination was non-contributory.

*Hospital Case No. CH 32492

Diagnosis

The diagnoses on admission were:

1) Primary Herpetic Gingivo-stomatitis with secondary dehydration

2) Arsenical intoxication

The significant laboratory studies on admission were as follows: urinalysis revealed acetonuria and a specific gravity of 1.020; the white blood cell count was 10,500 per mm of which 89% were polymorphonuclear cells.

Differential Diagnosis

ALEX J. STEIGMAN, M.D.: Herpes Simplex Virus is the commonest cause of gingivo-stomatitis in children. Indeed in this case there was a striking family epidemic beginning in the two and a half year old sister. The painful mouth generally causes difficulty in eating or sucking. Other causes of stomatitis must be considered.

Vincent's infection or trench mouth is less common in children. This is caused by a spirochete and a fusiform bacillus. Unlike herpetic gingivo-stomatitis the gums demonstrate an actual loss of substance due to tissue destruction despite the local edema and swelling. The most marked destruction is seen with tonsillar involvement, but even in gingival Vincent's infection, erosion of gums occurs.

In younger children Monilia Albicans can cause thrush stomatitis with white adherent elevated patches. It generally occurs in newborn, prematures or debilitated children.

A completely unrelated disease, herpangina (caused by Group A Coxsackie Virus) should cause no confusion in diagnosis. Fever, headache, and small ulcers appearing in the posterior pharynx and on the anterior tonsillar pillars with less marked cervical adenopathy characterize herpangina. These ulcers are surrounded by a red areola, are few in number and seldom occur in the anterior part of the mouth. The gums are not involved.

Management

WILLIAM CURTIS ADAMS, M.D.: The intense dehydration was corrected at once

with fluids Arsenical intoxication was strongly suspected in this gravely ill boy who had been given 0.6 grams of Neo-arsphenamine, intravenously, the day before. Accordingly BAL was administered. In an effort to alleviate the severe pain a mild local anesthetic, "Tronothane" was applied to the involved areas before fluids were offered. Unfortunately no systemic or topical medication is known to accelerate healing in Primary Herpetic Gingivo-stomatitis. Cold food and liquids rather than warm are generally better taken by these children.

Discussion

Dr. Steigman--

Question: Is it known why the Neo-arsphenamine was administered?

Answer: No. Perhaps the attending physician erroneously believed that this patient had Vincent's infection. At one time arsenicals were used for spirochetal infections, but penicillin has replaced that.

Question: Is BAL (British Anti Lewisite) better than versenate in treating arsenical poisoning?

Answer: Yes. Versenes are used for other heavy metal poison, (vis) lead.

Question: In what way is the virus of Primary Herpetic Gingivo-stomatitis related to the virus causing "fever blisters" or "cold sores?"

Answer: It is the same virus. By adulthood most of us have been infected with herpes simplex virus, most of us asymptomatically. Primary Herpetic Gingivo-stomatitis, as indicated by its name, is the patient's initial infection by the virus. Following the initial infection the virus may reside latently in the skin, most frequently in the perioral area. A variety of unrelated conditions, (viz) infectious, metabolic and emotional upsets, menstrual cycles, etc. may be accompanied by viral reactivation causing a "fever blister."

Question: What are the complications of Primary Herpetic Gingivo-stomatitis?

Answer: The skin around the mouth and nose may have satellite lesions due to direct spread. Herpetic Paronychia may occur if the child sucks his fingers. The dehydration resulting from a restricted intake and vomiting is of greater significance and requires prompt correction.

Question: Does Herpes simplex virus have any form of primary disease other than that presented by this patient?

Answer: Yes. The following table will show these manifestations:

A. Common
   1. Primary Herpetic Gingivo-stomatitis
   2. Silent skin infection

B. Less Common
   1. Primary Herpetic vulvovaginitis. These lesions are similar to those of the Herpetic Gingivo-stomatitis.
   2. Viscero-necrosis of newborns, especially of the liver and adrenals.
   3. Eczema herpeticum. The superimposition of the herpetic lesion upon active atopic eczema.
   4. Traumatic Herpes. Seen in children after a burn or abrasion.
   5. Herpetic dendritic keratitis.
   6. Herpetic meningo-encephalitis. The demonstration of neutralizing and complement fixing antibodies establishes the herpes simplex virus as one of the causative agents of the acute aseptic meningitis syndrome.

Question: What are the techniques used to cultivate the herpes simplex virus?

Answer: The virus may be cultured in the chorio-allantoic membrane of the chick embryo or on the scarified rabbit cornea, and in some tissue cultures.

Question: I believe there are antibody titers that can be done which may be helpful. Would you explain these?

Answer: In primary herpetic infections both neutralizing and complement fixing antibodies appear and start to rise within the first week of infection. Recurrences of herpes simplex are not related to antibody levels, however.

Question: What was the patient's course in the hospital?

Dr. Adams: He remained in the hospital for eight days. Intravenous fluid therapy was needed for two days. He was then able to take adequate ice cold fluids by mouth, if preceded by the application of a mild local anesthetic, Tronothane.

Although markedly improved the herpetic lesions were still evident at discharge. The lesions cleared completely during the following two week period.

BRUCE UNDERWOOD—THE PROGENITOR OF PROGRESS

"Progress through Organization" have been the key words—the underlying theme—that has characterized the very successful seven and one half years administration of Bruce Underwood, M. D., as Secretary and General Manager of the Kentucky State Medical Association. Dr. Underwood resigned from this position February 1, 1956 to take a position with the United States Public Health Service in Washington, D. C.



Dr. Underwood

This article will attempt to point out only some of the more important developments in the KSMA during the past seven and one half years. Neither time nor space permits us to undertake a full account of all that has happened since July 1, 1948 when Dr. Underwood became associated with us.

Before any progressive steps toward expanding the association services could be undertaken, authority had to be given by the Constitution and By-laws. Working with the KSMA officers and Council, Dr. Underwood was instrumental in re-writing the Constitution and By-laws, which had gone virtually unchanged since 1903. With this accomplished the KSMA was then in a position to move forward.

The new By-laws made is possible for the House of Delegates to accept Dr. Underwood's recommendations relating to improving parliamentary procedures. The result was the establishment of the present reference committee system. This streamlining of the House procedures, has contributed to more efficient handling of the organization's ever increasing volume of official business.

The new By-laws also increased the number of councilor districts, thus guaranteeing more equitable representation. In addition the By-laws made possible the formation of the Executive Committee of the Council to assist the Council. It is the function of the Council to carry on the business of the Association between meetings of the House of Delegates.

At the December 1949 meeting of the Council, I distinctly recall the decision of the Council to expand the Association's services. Dr. Underwood was authorized to employ full time executive and field secretaries and set up a Headquarters Office. Also at this meeting, Dr. Underwood suggested that the Council activate a Grievance Committee. This was done and Kentucky became the fifth state association to have one.

Other better known KSMA activities in which Dr. Underwood has been instrumental in setting into motion include the County Society Officers Conference, the Rural Health Council and a conference it sponsors, Physician Placement Service, Public Health, Veterans Affairs, Medical Service and Public Relations Committees, and development of monthly Secretary's News Letters for all KSMA members.

The vigor of Dr. Underwood's administration was again demonstrated as Editor of the Journal of the KSMA. Working with the Advisory Committee to the editor—also provided for by the new By-laws—major improvements were effected. These included the establishment of a Board of Consultants on Scientific Articles, which has had a tremendous influence on elevating the scientific content of the Journal. In addition four scientific departments have been established and are edited by outstanding members. The Journal was given a new format with organizational news included. Gross advertising revenue nearly doubled.

In the past seven and one half years, the KSMA Annual Meeting has become one of the best. The recommendation of the Secretary and General Manager that more outstanding guest speakers be obtained was approved. Revenue from technical exhibits has more than doubled.

Dr. Underwood was chosen as one of KSMA's delegates to the AMA in 1950. He soon became well and favorably known in the nation's medical policy making group, being appointed to serve on numerous committees of that organization. He was instrumental in having the other Kentucky delegate, Clark Bailey, M. D., elected vice president of the AMA in 1954-55. Dr. Underwood served both as secretary and as chairman of the Aces and Deuces Club, an organization of states that have one or two delegates to the AMA.

On still another front, Dr. Underwood encouraged the KSMA to be more active in supporting better medical and health legislation. He actively participated in the drafting and passing of the new Medical Practice Act in 1952. He was also active in

(Continued on page 166)

EDITORIALS

BON VOYAGE

Bruce Underwood, M. D., has resigned his position of Health Commissioner of Kentucky and will go to a new public health post in Washington, D. C. We had wished and hoped never to read such an announcement, but in due course it came. Now we must start all over again and must necessarily lose some of the gains accomplished during the past seven and one-half years.

Dr. Underwood is a Kentuckian. He was born and reared here, received his preliminary and medical education here, his public health training elsewhere, but returned to his native state in public health and private practice and later became commissioner of health—a position he has held with distinction for seven and one-half years. The welfare of Kentucky has been his prime motive to which he has addressed himself with unselfish and tireless devotion. He has been at great pains to acquaint himself with the most progressive and beneficial health measures in experiment or practice throughout the United States and has sought, whenever possible, to bring home to us the best and most effective.

During his tenure of office he has grown in stature professionally in his special field of public health and also in the general medical organization. As a delegate to the AMA for five years, he has represented us well and his work there has been outstanding. His ideas have helped to mold the pattern of medicine in this unsettled and critical period. His viewpoint has always been chiefly that of the private practitioner, from which status he was recruited for commissioner.

It is particularly unfortunate that his departure is scheduled during the early weeks of the 1956 legislative session. He served as chief health officer of the state through the last three sessions and had become conversant with the processes of legislation — an accomplishment which proved of decided advantage to the health and welfare of the state. There are, of course, others who will carry on well toward the health objectives already established—but the loss of Dr. Underwood's leadership in this activity will be acutely felt.

Through the years we have observed many promising and brilliant young Kentuckians, educated in our school and receiving their post-graduate training elsewhere, pitch their tent in the lusher lands of their adoption, never to return. They have struggled along, as young physicians do, while their homefolks watched them with interest and anticipation. Then they began to grow. Slowly they gained stature among their fellows, often standing a full head and shoulders above them, until they were seen and known from afar—sometimes real giants in medicine. They brought such distinction and pride to their native state that eventually we were glad they had gone where they might become bigger, and accomplish greater things than they ever could at home.

Our best wishes follow you, Bruce, in your new endeavor. You have served Kentucky well. You have given service in full measure, pressed down and running over for all that we gave you. We will follow your further growth and accomplishments with more than passing interest.

Sam A. Overstreet, M.D.

Opinions expressed in contributions to this Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

MEDICAL STATESMANSHIP OR MEDICAL POLITICS

"All cut and dried." "I see the clique has things under control as usual." "Who has the gang decided shall be elected this year?" Such expressions are heard frequently at each meeting of the State Medical Association, and occasionally at other times. Such conclusions are not supported by the facts.

There may be too many committee reports. Probably some reports are too long and involved to admit proper understanding. Some reports may be repetitions of those of the last year and the year before. Some delegate may discount the value of a report not read before the House of Delegates. A committee report may recommend a change in policy not apparent to the delegates. The reference committees may not have enough time to carefully read all reports intrusted to them, and to consider them in detail.

The volume of business before the KSMA requires an agenda to avoid chaos. A planned program does not indicate a desire to confuse or mislead. It is an effort to expedite the handling of matters which come before the delegates. Either a reduction in the agenda or an additional session of the House of Delegates seems indicated.

The House of Delegates always has a number of familiar faces. Less notice is taken of delegates who represent their county societies less frequently. The men who appear on the rostrum have usually been there before. This does not indicate that a clique is in firm control. On the contrary it is proof of the continuity of the program of the KSMA. A certain number of "old pros" are desirable to keep the machinery running. An officer of the association, regardless of his ability, is a better officer if he has served an apprenticeship in a less responsible position. It is not a selfish task to serve as delegate, councilor, committee member or otherwise. It represents a sacrifice of time and effort, and an interest in good medical organization.

For many years it has been our custom to choose the president elect and vice-presidents on the basis of three sections of the state. The nominating committee is elected by the House of Delegates. This committee makes an honest effort to select good nominees. It may err despite the best of motives. The committee will welcome suggestions from any member of the association; it will resent any dictation from any officer. Among the criteria used in selection are the following: 1. Professional ability and standing. 2. Good comport with colleagues. 3. Interest in county and state medical organizations. 4. Leadership acceptable to the majority of members of the KSMA. Any delegate who disagrees with the action of the nominating committee should not hesitate to nominate his choice.

Each delegate is the servant of the county society which elects him. Each officer is the servant of the House of Delegates which elects him. The House of Delegates controls the policy of the association; which it establishes, maintains or alters as it sees fit. The key to medical statesmanship is an active interest by every member in the business sessions of the county medical society. No man should accept the responsibility of delegate if unwilling to function in that office. There will be an occasional physician who will place self interest above that of the profession as a whole. We, as members of county medical societies, determine whether the KSMA is under the control of medical statesmen or medical politicians. We are the Kentucky State Medical Association.

W. B. ATKINSON, M.D.

BRUCE UNDERWOOD

(Continued from page 164)

the national scene in this field, and served as chairman of the committee that drafted the uniform medical practice code of the Federation of the State Medical Examiner Boards.

The most important thing Dr. Underwood did, in our opinion, was to bring the KSMA to a point where it had the mechanism to manage its own affairs. I remember very well when Dr. Underwood said back in December 27, 1951, at a meeting of the Council, "As of now, I am able to report the affairs of the Association are now in your hands—policy will not be made by us here in the Headquarters Office from now on."

Yes, "progress through organization" has been demonstrated by Dr. Underwood's administration. We are all reluctant to give him up—yet we will be forever indebted to him for his many contributions. Because of these contributions—the KSMA is now in a position to continue to progress and extend its usefulness—and will do just this with your continued support.

J. VERNON PACE, M.D.
Chairman of the Council

ORGANIZATION SECTION

Sixth Annual County Society Officers Conference Scheduled for Thursday, March 29 in Lexington at Phoenix Hotel

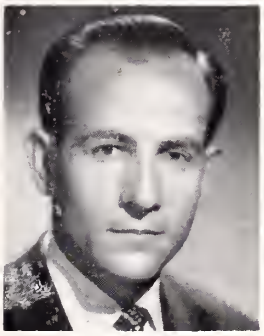
County Medical Leaders to Hear Top Experts from Both Coasts on Local PR and PS Matters

County medical society leaders within the KSMA will hear top experts in the field of medical public service and relations and will have a rare opportunity to discuss their local problems with these experts on March 29, 1956.

An unusually strong program will be presented at the sixth annual County Society Officers Conference at the Phoenix Hotel in Lexington, according to Gant Gaither, M.D., Hopkinsville, KSMA President.

"Every county medical society officer, committee chairman and KSMA officer and committee chairman will find this an unusual opportunity to get assistance in this most important phase of County Society activity," Dr. Gaither said. All members of KSMA are invited to attend. Members of the Board of Directors of the Woman's Auxiliary to the KSMA will also be present.

The following distinguished men will participate in the program.



Mr. Pettis

Jerry Pettis, past associate director of Public Relations of the California Medical Association, is the assistant to the President and Public Relations Counsel of the Los Angeles County Medical Association. Mr. Pettis, who has had wide experience in implementing policies of California physicians and work with welfare medical plans in various California industries, is president of Jerry Pettis and Associates, a company specializing in Public Relations. A member of the Public Relation Society of America, Mr. Pettis is a consultant in the television show "MEDIC." He will speak on "The Usual Fee and Third Party Medicine."

Dwight Murray, M.D., President-elect of the AMA, is chairman of the AMA Board of Trustees. In a speech at the recent AMA PR Conference Dr. Murray said the medical profession had done a good formal PR job, but had often ignored the simplest and most effective medium of communication—"word of mouth, neighbor-to-neighbor, and person-to-person." Dr. Murray will elaborate on this theme and discuss other PR problems in a talk entitled "A Master Plan for County PR."



Dr. Payne

C. Allen Payne, M.D., a pathologist at Blodgett Memorial Hospital in Grand Rapids, Michigan, is chairman of the Public Relations Committee of the Michigan State Medical Society. In Dr. Payne's talk entitled "The Greatest Potential Asset of the County Medical Society" he will discuss the problems of indoctrination and orientation of young physicians in the private practice of medicine.



Dr. Chadwick

Alfred E. Chadwick, M.D., a general practitioner from New Brighton, Pennsylvania, is a member of the Public Relations Committee of the Pennsylvania State Medical Society. Dr. Chadwick, who has had much experience getting county societies to work in effective public relations programs at local level, will speak on "Public Relations at Work."



Dr. Allman

David Allman, M.D., a surgeon from Atlantic City, is Chairman of the AMA Legislative Committee. He is a member of the Board of Trustees of the AMA. Dr. Allman will discuss the topic "Medical Legislation on Capital Hill" at the Conference.

PROGRAM

Sixth Annual County Medical Society Officers Conference

Phoenix Hotel, Lexington **Thursday, March 29, 1956**

MORNING SESSION

Gant Gaither, M. D., Hopkinsville, presiding
President, Kentucky State Medical Association

9:45 A. M. **Welcome.** John S. Sprague, M.D., Lexington
President, Fayette County Medical Society

9:50 **"How Do You Rate Doctors?"**
Leo Brown, Chicago, Illinois
Director, AMA Public Relations

10:10 **"The Greatest Potential Asset of the County Medical Society"**
C. Allen Payne, M.D., Grand Rapids, Michigan

10:30 **"The Usual Fee and Third Party Medicine"**
Jerry Pettis, Los Angeles, California

INTERMISSION (5 Minutes)

10:45 **"Public Relations at Work"**
Alfred E. Chadwick, M.D., New Brighton, Pennsylvania

11:15 **"Experts on the Spot"—Panel**
Clyde C. Sparks, M.D., Ashland, Moderator
Past President, KSMA

12:15 **Lunch**

AFTERNOON SESSION

Richard Slucher, M.D., Louisville, presiding
President-elect, KSMA

1:00 P. M. **"A Master Plan for County PR"**
Dwight Murray, M.D., Napa, California
President-elect, AMA

1:30 **"Medical Legislation on Capital Hill"**
David Allman, M.D., Atlantic City, N. J.
Chairman of AMA Legislative Committee

2:00 **"The Impact and Effect of the International Labor Organization upon World Affairs"**
William McGrath, Cincinnati, Ohio
Employer's Delegate to the ILO

2:40 **Discussion**
J. Vernon Pace, M.D., Paducah
Chairman of the Council, KSMA

3:00 **Adjournment**



Mr. Brown

Leo Brown is Director of Public Relations at the American Medical Association. Mr. Brown will speak at the conference on the results of a recent public opinion survey made by the AMA. His talk will be entitled, "How Do You Rate Doctors?" He indicated that preliminary viewing of the survey showed that it was well done and quite complimentary to medicine.

William McGrath, Cincinnati, Ohio, the employer's delegate to the International Labor Organization, will discuss "The Impact and Effect of the International Labor Organization Upon World Affairs." Mr. McGrath has devoted much time to the ILO by attending its conferences at Geneva for the last seven years.

A panel discussion entitled, "Experts on the Spot" will be moderated by Clyde C. Sparks, M.D., Ashland, past president of the KSMA. Mr. Brown, Dr. Payne, Dr. Chadwick and Mr. Pettis will be panel members.

J. Vernon Pace, M.D., Paducah, Chairman of the Council, will act as moderator of a discussion which will conclude the afternoon session.

Dr. Gaither will act as presiding officer over the morning session. Richard Slucher, M.D., Louisville, President-elect, will preside over the afternoon session.

The conference will begin at 9:40 A. M. with a welcome by John Sprague, M.D., President of the Fayette County Medical Society, and will end at 3 P. M.

Nominating Committee to Organize at County Officers Meeting

The KSMA nominating committee will have a special table at the County Society Officers Conference Luncheon March 29 in Lexington at the Phoenix Hotel, at which time they will organize.

The committee will be available for consultation to any member wishing to make recommendations of colleagues to fill the various general offices for the 1956-57 year.

The committee will announce its final recommendations, according to By-law provisions, at the second scientific session Tuesday afternoon, September 18, during the 1956 meeting. The House of Delegates will vote on these nominees at its second session Wednesday, evening, Sept. 19. Additional nominations can be made from the floor.

The House of Delegates selected five men at its last meeting to serve on this committee. They are: W. B. Atkinson, M.D., Campbellsville; Howell J. Davis, M.D., Owensboro; Thomas J. Gilbert, M.D., Bowling Green; John S. Harter, M.D., Louisville; and H. B. Stone, M.D., Hopkinsville.

Council Selects Dr. Troutman Secretary-Editor Pro tem

Woodford B. Troutman, M.D., Louisville, was named Secretary-Editor pro tem of the Kentucky State Medical Association at a meeting of the Council Thursday, January 5. Dr. Troutman has served as the KSMA Treasurer since April 17, 1946.



Dr. Troutman

The Council took this action following the resignation of the Association's twentieth secretary, Bruce Underwood, M.D., on Dec. 15. Dr. Underwood has taken a position in Washington, D. C., with the United States Public Health Service, in the Department of Health, Education and Welfare.

For the past half century, it has been traditional for the Secretary of the KSMA to also be Health Commissioner for the State of Kentucky. Just prior to the election of Dr. Troutman, the Council voted, pending final action of the House of Delegates in September, that the Secretary of the KSMA and the State Health Commissioner should not be the same person.

"The fact that it is not planned in the future that the Commissioner of Health and the Secretary-Editor of the KSMA be the same individual does not mean that we in the Medical Association do not have the highest respect for the Health Department and the greatest desire to continue the closest cooperation with it," J. Vernon Pace, M.D., Chairman, said after the Council had acted.

Following his selection, Dr. Troutman said he planned to make no changes in the policy of the Secretary-Editor's office.

Arthur T. McCormack, M. D., succeeded James B. Bullit, M.D., in 1907 and served as Secretary-Editor of the KSMA and Health Commissioner till his death in 1943. He was followed by his long time deputy commissioner, Philip E. Blackerby, M.D., who held the two positions until his death in 1948. Dr. Underwood took office July 1, 1948.

MDs Can Name Award Candidates at County Officers Meeting

All KSMA members who wish to recommend candidates to receive the Distinguished Service Medal and the Outstanding General Practice Award will have the opportunity to submit these names to members of the Awards Committee at the Luncheon at the County Society Officers Conference, March 29, at the Phoenix Hotel in Lexington.

The committee which was activated at the 1954 Annual Meeting will have a special table at the luncheon, according to Charles Vance, M.D., Lexington, Speaker of the House.

The committee will report its recommendations at the first meeting of the House of Delegates, Sept. 17, 1956. At the second meeting, Sept. 19, additional candidates can be nominated from the floor.

The five member committee includes: Ernest Strode, M.D., Lexington, Chairman; Hugh Adkins, M.D., Louisville; Joseph Kurre, M.D., Owensboro; Frank Sewell, M.D., Mt. Sterling; and Charles Yancey, M.D., Hopkinsville.

AMA Dues Paying Members Have Choice of Ten Journals

Dues paying members of the American Medical Association may have their choice of AMA publications—either the AMA Journal or one of the nine special Journals.

Secretaries of county societies can get subscription cards for their members by writing to Robert Enlow, Director; Membership-Circulation Department; 535 N. Dearborn, Chicago.

The nine special Journals are: Archives of Internal Medicine; American Journal of Diseases of Children; Archives of Dermatology; Archives of Neurology and Psychiatry; Archives of Pathology; Archives of Surgery; Archives of Otolaryngology; Archives of Ophthalmology, and Archives of Industrial Health.

Chandler Backs New Med School at University of Kentucky

Governor A. B. Chandler recently told the members of the Kentucky Medical Foundation that he will back the building of a new medical school at the University of Kentucky in Lexington.

Governor Chandler said he would ask the General Assembly to appropriate funds to start the building plans "at the earliest possible moment."

It has been estimated that a school at UK would cost $16,000,000. Ten million of this amount would be sought from the state. The University of Louisville Medical School receives $300,000 a year from the Medical Research Commission that is appropriated by the Legislature.

AMA Plans Three New Series of Radio Transcriptions

The new radio transcription series sponsored by the AMA and carried by approximately 28 Kentucky radio stations will be changed in 1956, according to the AMA Bureau of Health Education.

Three new series of 13 programs each are planned by the Bureau. The first will feature a "music with your meals" theme. W. W. Bauer, M.D., Bureau director, will give a medical commentary on 13 different phases of diet and nutrition. An instrumental trio will play folk songs, ballads and semi classics.

"Summer Serenade" is the theme of the second in the series which will deal with summer health situations. The topic of the third has not been released.

The KSMA Committee on Public Information and Service will be glad to cooperate with any County Medical Society in having the local radio stations, not acquainted with these programs, get the platters, Richard G. Elliott, M.D., Lexington, committee chairman said.

14th District to Hold Meeting

The 14th Councilor District will have an afternoon and evening scientific meeting at the Paintsville Country Club April 19, according to John Archer, M.D., Prestonsburg, Councilor from this district.

Gant Gaither, M.D., Hopkinsville, KSMA President, will be the featured speaker. Johnson County Medical Society will be the host society.

First District to Meet April 25

Gant Gaither, M.D., Hopkinsville, KSMA President, will be the featured speaker at the First Councilor District Meeting in Paducah at the Ritz Hotel, April 25, according to J. Vernon Pace, M.D., Paducah, Chairman of the Council.

The McCracken County Medical Society will be the host society at the meeting.

Medical Association Establishes Physician Loan Program

A new program to help physicians secure loans at low interest rates has been developed by the Los Angeles County Medical Association. The new loan system was established with the belief that the public will receive better medical service from a physician who has few financial problems.

The LACMA has arranged for the loans in cooperation with a local Bank and Trust Company. The medical association first screens the applicants, then if approved, they are turned over to the bank for further screening. If okayed by the bank the applicant fills out the regular bank loan application.

Kentucky medical associations desiring further information relative to the loan program set-up can write to the Business Manager, Mr. Bert Fitzgerald, at LACMA Headquarters, 1925 Wilshire Boulevard, Los Angeles 57.

Frank M. Gaines, M.D., Louisville Honored by Station WHAS

Frank M. Gaines, M.D., Louisville, Kentucky's Commissioner of Mental Health, was named Kentucky's top personality of 1955 by Victor A. Sholis, Vice President and Director of WHAS. Dr. Gaines was presented an engraved silver platter.

Dr. Gaines, a 1941 graduate of the University of Louisville School of Medicine, is chairman of the Southern Regional Council on Mental Health Training and Research.

Margaret Morgan, M.D., a classmate of Dr. Gaines at the U of L School of Medicine, and Indiana's Commissioner of Mental Health, received a similar award when named Indiana's top personality of 1955.

Ike Questionnaire Criticized

A questionnaire sent to heart specialists asking their opinions of President Eisenhower's physical ability to seek re-election was criticized by the Journal of the AMA recently. The questionnaires were mailed by the American Research Foundation, Princeton, N. J.

The questionnaires, which required no signature and gave no hint as to how information would be used, asked these questions: 1. Do you think a man who has suffered a heart attack can be regarded as physically able to serve a term as President? 2. Based on what you have read about the nature of the President's illness, and assuming a normal convalescence in the next few months, do you think Mr. Eisenhower can be regarded as physically able to serve a second term?

New Clinic Opens At Henderson

The opening of a new clinic at Henderson was recently announced.

Six physicians make up the staff. They are: Charles C. Kissinger, M.D., General Surgery; Walter L. O'Nan, M.D., Obstetrics and Gynecology; Millard R. Shaw, M.D., Internal Medicine; Robert L. Sumner, M.D., General Medicine; Don A. Cantley, Jr., M.D., Pediatrics and Samuel D. Taylor, M.D., General Medicine.

Dr. Ling Succeeds Dr. Kerman

J. T. Ling, M.D., Louisville, was recently named director of the Radioisotope Laboratory and Radiation Treatment Section of the University of Louisville Medical School. Dr. Ling, a native of Shanghai and assistant professor of radiology at the Medical School, succeeds Herbert Kerman, M.D., who resigned to enter private practice in Florida.

Dr. Haynes Is OB-GYN Fellow

Douglas M. Haynes, M.D., Louisville, was inducted in the American Academy of Obstetrics and Gynecology at the Annual Business Meeting in Chicago, Dec. 12-14, 1955. Announcement of the induction was made by the secretary, Paul Hodgkinson, M.D., Chicago.



The 1956 KSMA County Society Officers Conference will be held at the Phoenix Hotel in Lexington, Thursday, March 29.

Attention Scientific Exhibitors!

Everett L. Pirkey, M.D., Chairman of the Committee on Scientific Exhibits, has urged prospective scientific exhibitors for the 1956 Annual Meeting to make their reservations for space soon.

The application blank on page 154 should be filled out and mailed before July 1, 1956.

AMA to Publish Two Booklets

The AMA will publish, early in February, two booklets that will be of interest to Kentucky medical societies. These booklets are "Guides for Medical Society Grievance Committees" and "Report of the Survey on County Medical Society Activities."

Copies of these booklets will be available at the KSMA Headquarters Office in February.

Shelbyville's Dr. Weakley Honored

A. C. Weakley, M.D., Shelbyville, was honored with a surprise party Dec. 15 for his 41 years of service to Shelby County.

The party, held at the Old Stone Inn in Simpsonville, was patterned after the television show "This Is Your Life." Dr. Weakley's life was traced from 1914 when he began practice in Shelby County to the present.

Allergists to Meet in New York

The American College of Allergists will hold a Graduate Instructional Course and a Twelfth Annual Meeting in New York City at the Hotel New Yorker, according to Fred Wittich, M.D., Secretary-Treasurer of the group. The graduate course will run from April 15-17 and the Annual Meeting from April 18-20.

New KSMA Members

The following physicians have been added to the KSMA membership roster. They are:

David C. Asher, M.D., Pineville
William N. Bennett, M.D., Pineville
L. F. Boland, M.D., Frankfort
Thornton Bryan, Jr., M.D., Frankfort
John B. Clay, M.D., Frankfort
J. F. Daugherty, M.D., Independence
Norman B. Hasler, M.D., Waverly Hills
Clarence Hicks, M.D., Middlesboro
Fred Pipkin, M.D., Louisville
James R. Rich, M.D., Independence
George Schafer, M.D., Louisville
John B. Southard, M.D., Louisville.

News Items

Thornton E. Bryan, M.D., has opened offices in Cadiz for general practice. Dr. Bryan is a 1954 graduate of the University of Louisville School of Medicine. He served his internship at Philadelphia General Hospital in Pennsylvania. Recently Dr. Bryan received special training in the administration of anesthetics at the Louisville General Hospital. Dr. Bryan took the office formerly occupied by Leslie Blakey, M.D., who moved to Rochester, Minn., in December.

Leslie Blakey, M.D., former Cadiz physician, has been appointed to a three-year fellowship in internal medicine at the Mayo Clinic in Rochester, Minn. Dr. Blakey is a graduate of the University of Louisville School of Medicine Class of 1947.

Richard M. Brandon, M.D., a '54 graduate of the University of Louisville School of Medicine, joined the staff of the Trover Clinic in Earlington. Dr. Brandon interned at the St. Elizabeth Hospital in Covington.

A. Keith Anderson, M.D., of Oakland California, has become associated with the Oneida Mountain Hospital. He will go to Booneville where he will conduct a general practice and open a clinic. Dr. Anderson was graduated from the College of Medical Evangelists School of Medicine, in Los Angeles. He interned at Loma Linda Sanitorium Hospital in Loma Linda, California.

John Southard, M.D., has opened an office for general practice in Louisville. A '54 graduate of the University of Louisville School of Medicine, Dr. Southard interned at Brook Army Hospital in Fort Sam Houston, Texas.

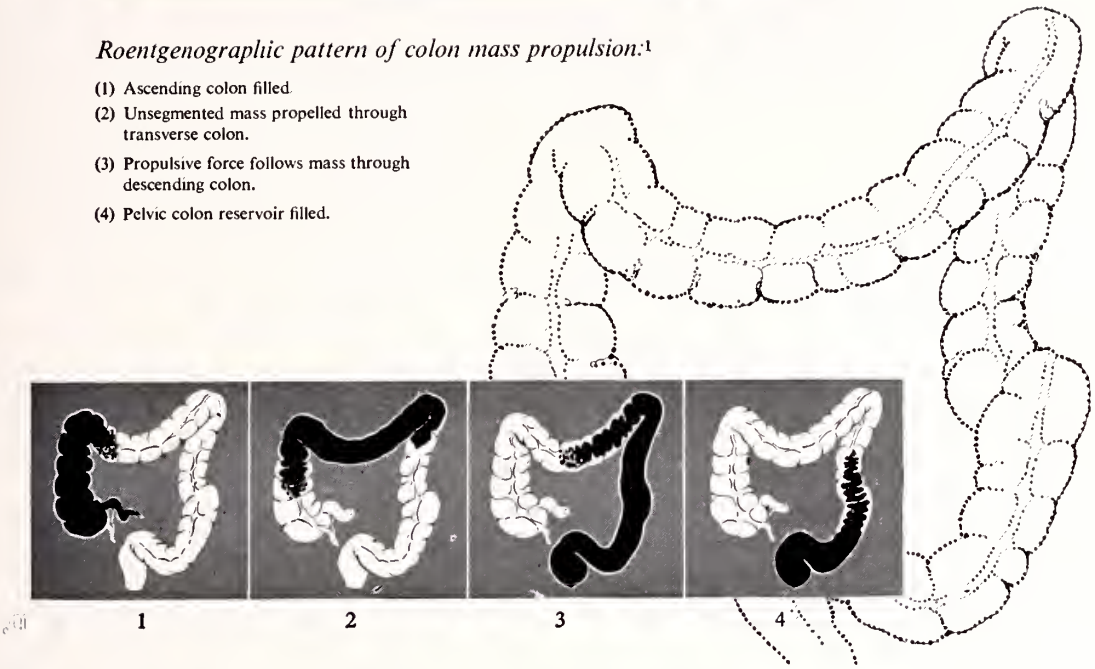
Elwood Woolsey, M.D., has joined the staff of the UMW Hospital in Harlan. Dr. Woolsey interned at the Alameda County Hospital in Oakland, California and served residencies in OB-GYN at Stanford University Hospital in San Francisco and San Francisco County Hospital.

William Shidal, M.D., a '53 graduate of the University of Louisville, is serving a residency in pediatrics at St. Joseph Infirmary in Louisville. Dr. Shidal interned at St. Elizabeth Hospital in Covington.

SMOOTHAGE ACTION IN CONSTIPATION

Roentgenographic pattern of colon mass propulsion:[1]

(1) Ascending colon filled.
(2) Unsegmented mass propelled through transverse colon.
(3) Propulsive force follows mass through descending colon.
(4) Pelvic colon reservoir filled.



Reestablishing Bowel Reflexes with Metamucil®

Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.[2]

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of Plantago ovata) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.[2]

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. G. D. Searle & Co., Research in the Service of Medicine.

1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.
2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

SEARLE

Herman D. Kerman, M.D., former associate professor of radiology at the University of Louisville School of Medicine, resigned to enter private practice in Florida. Dr. Kerman, a graduate of Duke University School of Medicine, Durham, N. C., has been director of the radioisotope laboratory at General Hospital, Louisville. He is a member of the board of teletherapy evaluation at the Oak Ridge Institute for Nuclear Studies.

George McCrocklin, M.D., a '50 graduate of the University of Louisville School of Medicine, has opened offices in Louisville. Dr. McCrocklin will limit his practice to orthopedic surgery. He interned at Louisville General Hospital and has been with the VA Hospital since 1951.

OMISSION

The place of presentation of the scientific article "Use of Trypsin in Inflammation" was omitted when published in the January 1956 Journal, page 43. Bert Seligman, M.D., Toledo, Ohio, presented the paper at the 1955 Annual Meeting of the Kentucky Chapter of the American Academy of General Practice, April 21 in Louisville.

COUNTY SOCIETY REPORTS

CALLOWAY

The meeting of the Calloway County Medical Society was held in the Murray Hospital, November 1, 1955.

The society agreed to give $200 to the Hospital Auxiliary to be used in whatever manner the hospital administrator sees fit.

A discussion was held on a pending lawsuit filed by a radiologist in Scottsville against a hospital.

Hugh Houston, M.D., Secretary

CALLOWAY

The December meeting of the Calloway County Medical Society was held in the dining room of the Murray Hospital. Robert Hahs, M.D., vice-president called the meeting to order.

C. H. Jones, M.D., president, presided over the election of officers. The following officers were elected for 1956:

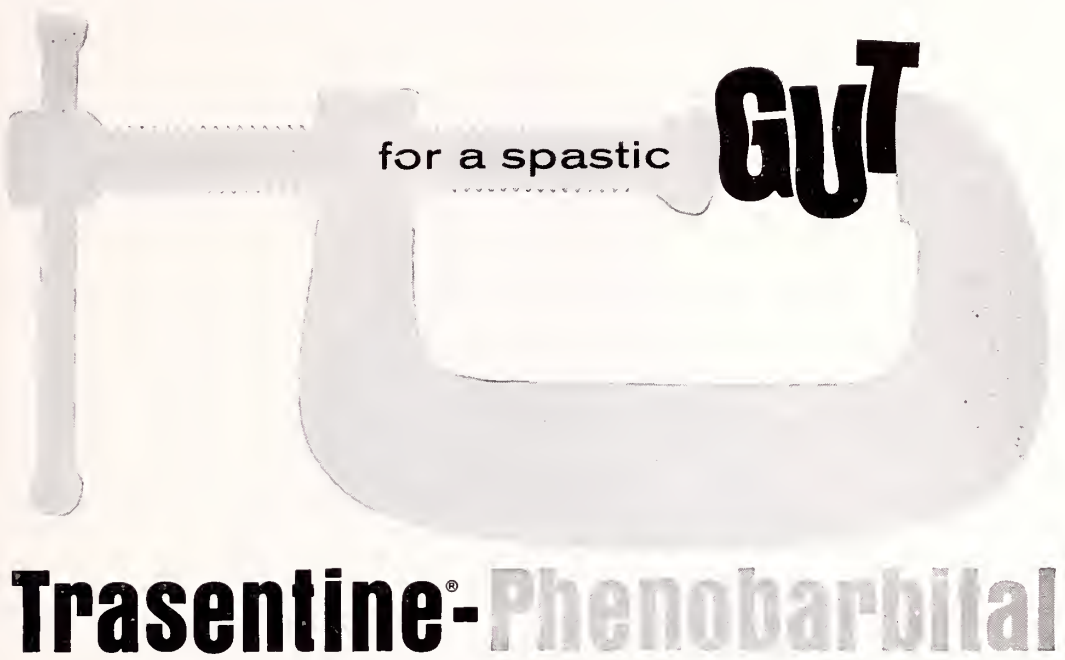
Charles Clark, M.D., president, and A. D. Butterworth, M.D., vice-president. Hugh Houston, M.D., will finish out his term of two years as secretary-treasurer, and A. D. Butterworth,

Relax the best way
... pause for Coke



continuous quality
is quality you trust

DRINK
Coca-Cola
REG. U.S. PAT. OFF.



integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

2/2228M

CIBA
Summit, N. J.

MEDICAL HORIZONS TV Monday P.M. *Sponsored by* CIBA ABC-TV

M.D., will complete his two year term as KSMA delegate.

Hugh Houston, M.D., Secretary.

LETCHER

Owen Pigman, M.D., was re-elected president of the Letcher County Medico-Dental Society at a meeting December 27. Also re-elected were: Lee Moore, D.D.S., vice-president; R. Dow Collins, M.D., secretary-treasurer; Carl Pigman, M.D., 1956 Annual Meeting delegate and B. C. Bach, M.D., alternate delegate.

Committee chairmen were appointed at the meeting. They are: Carl Moore, D.D.S., Diabetes; Fred L. Coffey, D.D.S., Public Relations; Owen Pigman, M.D., Lee Moore, D.D.S., and R. Dow Collins, M.D., program; Lee Moore, D.D.S., Rural Health.

The group discussed the opening and staffing of the new UMW Hospital which opens in February at Whitesburg.

R. Dow Collins, M.D., Secretary.

McCRACKEN

James Headstream, M.D., Professor of Urology at the University of Arkansas, presented the scientific program at the November 16 meeting of the McCracken County Medical Society.

Associate membership in the society and a new type of collection agencies were other topics discussed at the meeting. The society agreed to hold a cocktail hour preceding the December business meeting.

Walter R. Johnson, M.D., Secretary.

McCRACKEN

The last regular monthly meeting of the McCracken County Medical Society was held December 21. Merle Fowler, M.D., president, presided.

Sydney Dyer, M.D., was accepted for membership in the society.

A motion was made stating that a Cardiac Evaluation Center for the medical needy be established in Paducah for the use of patients

referred by physicians of the First Councilor District. It was decided that the present Advisory Heart Committee (Rex Holland, M.D., W. P. Hall, M.D., and R. L. Reeves, M.D.) will work out the mechanism for establishing such a clinic, and handle all the publicity, and social service aspects. The committee is to present a report of the progress and activities of this clinic in six months.

The physicians were notified that adequate polio vaccine was available for immunization of children one to 10 years old and pregnant women.

A motion was made and seconded that the local county society dues be reduced from $15.00 to $5.00 for the coming year.

A motion was made and passed unanimously that the McCracken County Medical Society go on record as opposing the Social Security Bill, HR 7225. The new secretary was instructed to send letters, after the opening of Congress in January, to all senators and representatives of Ky., to inform them of the action.

J. Vernon Pace, M.D., Chairman of the KSMA Council, informed the group of the problems that confront the council and the House of Delegates in 1956.

The following officers were elected for 1956: Harold Priddle, M.D., president; Vernon Pettit, M.D., vice-president; Pitman Orr, M.D., secretary; Leon Higdon, M.D., KSMA delegate; and James Ward, M.D., alternate delegate.

James Ward, M.D., Charles W. Harting, M.D., and Charles Billington, M.D., were elected to the County Board of Health. New members of the Board of Censors are Charles E. Billington, M.D., James Ward, M.D., and Walter Johnson, M.D.

Walter Johnson, M.D., Secretary.

PIKE

The Pike County Medical Society met November 15, 1955 in Pikeville. Twenty four members were present.

An application for membership in the society was made by Ned R. Johnson, M.D. The application was referred to the Credentials Committee.

The group, after discussion, agreed to oppose the move to divide the office of the Commissioner of Health and the Secretary of the Kentucky State Medical Association.

G. N. Combs, M.D., Secretary-Treasurer

PIKE

J. E. Johnson, M.D., State Senator, spoke on the unity and strength of organized medicine

- **Tailored to your needs by a qualified, long-established organization**
- **Your opportunity to gain peace of mind from office and business worries**
- **Our services cover:**

Tax Returns
Bookkeeping and Monthly Reports
Servicing Delinquent Accounts—**No Commission**
Instructing Office Personnel
Fee Analysis and Comparative Statistics
Public Relations
Setting Up New Practices and Partnerships
Reviewing Plans for Retirement, Investments and Insurance

No charge for initial survey and no obligation to engage our services thereafter. Survey and subsequent contacts made only at your request. Service on month-to-month basis at reasonable cost.

Available

PROFESSIONAL BUSINESS MANAGEMENT

FOR DOCTORS ONLY

CLAYTON L. SCROGGINS ASSOCIATES
(MEDICAL - DENTAL MANAGEMENT)

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Alvin S. Haines

141 West McMillan Street
Cincinnati 19, Ohio
WOodburn 1-1010

I would like to know more about PBM.

Name .....

Address .....

..... Telephone.....

All Services Completely Confidential



*Trademark for the Upjohn brand of prednisone (delta-1-cortisone)

at the December 20 meeting of the Pike County Medical Society.

The application for membership of Edwin T. Thorsness, M.D., was turned over to the Credentials Committee.

The following officers were elected at the meeting.

F. H. Hodges, M.D., president; B. W. Cassady, M.D., secretary-treasurer. Dr. Hodges appointed the program committee

G. N. Combs, Secretary.

SCOTT

The Scott County Medical Society met January 5 at the John Graves Ford Memorial Hospital in Georgetown.

The dentists and pharmacists of Georgetown were invited to meet with the society at this meeting.

H. V. Johnson, M.D., secretary, was instructed to write to the Councilor and send him a copy of the motion protesting the purchase of polio vaccine by the state after February 1, 1956.

The following physicians attended the meeting: J. C. Cantrill, M.D., W. S. Allpin, M.D., A. F. Smith, M.D., H. G. Wells, M.D., F. W. Wilt, M.D., C. R. Lewis, M.D., E. C. Barlow, M.D., and H. V. Johnson, M.D.

H. V. Johnson, M.D., Secretary

SHELBY-OLDHAM

A. C. Weakley, M.D., Shelbyville, was honored at the December meeting of the Shelby-Oldham County Medical Society.

A "This Is Your Life" surprise party was given Dr. Weakley who has practiced medicine in Shelby County for 41 years.

A motion to change the name of the society to Shelby-Oldham-Henry County Medical Society was made and seconded.

C. C. Risk, D.D.S., Secretary

WARREN-EDMONSON-BUTLER

Martin Wilson, M.D., was elected president of the Warren-Edmonson-Butler County Medical Society at the December 13 meeting. John McKissick, M.D., was elected vice president and Keith Coverdale, M.D., secretary and treasurer.

J. T. Gilbert, Jr., M.D., was re-elected KSMA delegate and Harold Keen, M.D., was named alternate delegate.

Charles M. Francis, M.D., Secretary

In Memoriam

JAMES EDWARD HAGAN, M. D.

Hazard

1901 - 1955

Dr. Hagan, surgeon and one of the founders of the Hazard clinic, died Oct. 23. He was 54.

A 1923 graduate of the University of Tennessee Medical School, he had practiced in Hazard since 1929. He served three and one half years in the army in World War II.

Dr. Hagan had served as president and general manager of the Hazard Clinic, and was president of the Mount Mary Hospital staff.

IRA N. KERNS, M. D.

Louisville

1883 - 1955

Dr. Kerns, medical director for several Louisville industrial plants, died November 14 at his home. He was 72.

A 1905 graduate of the Kentucky University School of Medicine, Dr. Kerns conducted a general practice in Louisville. He was one of the founders and a charter member of the Blue Cross Hospital plan in Kentucky.

Past president of the Muldraugh Hill Medical Society, he was a member of the KSMA, AMA, American College of Surgeons and the Industrial Medical Association.

CHARLES A. NEAL, M.D.

Nicholasville

1899 - 1955

Dr. Neal died October 27 at the Good Samaritan Hospital in Lexington, after suffering a heart attack and paralytic stroke. A 1927 graduate of the Medical Department of the University of Louisville, Dr. Neal began practice in Nicholasville in 1937. In 1949 he was elected mayor of Nicholasville.

He was a member of Hart Lodge No. 61, the Nicholasville Methodist Church, KSMA and was secretary of the Jessamine County Medical Society.

LISTER COLLINS, M. D.

Mount Eden

1879 - 1955

Dr. Collins died at his home in Mount Eden, October 25. He had practiced medicine in Shelby County for more than 50 years.

A 1902 graduate of the University of Louisville School of Medicine, Dr. Collins began his practice at Duganville, in Mercer County, the

"Premarin" relieves menopausal symptoms with virtually no side effects, and imparts a highly gratifying "sense of well-being."

"Premarin" ®—Conjugated Estrogens (equine)

5511

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

same year. He moved to Mount Eden a few months later.

Dr. Collins retired from practice in July.

CHARLES N. KAVANAUGH, M. D.

Lexington

1892 - 1955

Dr. Kavanaugh, 63, died October 29, in Lexington.

A graduate of the Medical Department of the University of Louisville, Dr. Kavanaugh completed his internship at Boston City Hospital, after duty, during World War I, with the army artillery and medical corps units.

After completion of his internship he began practice in Lexington. Since 1922 he has been an associate of the Lexington clinic. He limited his practice to internal medicine.

ROBERT L. CHASE, M. D.

Glasgow

1917 - 1955

Dr. Chase was killed Oct. 9, when his car overturned on Highway 252. He was returning home from a night call in the Finney neighborhood.

Dr. Chase began practice in Glasgow seven years ago after leaving Akron, Ohio. He was associated with Clifton Richards, M.D., before the latter's death.

He was a member of the board of directors of the Glasgow Chamber of Commerce and a member of the First Methodist Church. He was elected president of the Glasgow Rotary Club this year.

H. C. JASPER, M. D.

Richmond

1865 - 1955

Dr. Jasper, 90, died at his home Dec. 15 after a long illness.

He was graduated from the Kentucky School of Medicine in 1889. After post graduate work in Philadelphia and New York City, he went to Richmond in 1889.

Dr. Jasper was a charter member of the Kentucky Association of Railroad Surgeons, a Mason, and a member of the Madison County Octogenarian Club and Baptist Church. He was active in the Madison County Medical Society, and was its second president.



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Members of the American Hospital Association and National Association of Private Psychiatric Hospitals

Five modern buildings, separate for men and women. Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD, Hospital Administrator

J. F. HALLER, Manager

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M. D., Neuropsychiatrist Medical Director

T. J. SMITH, M. D., Associate



In Colds... *Anywhere... Any time...*

Neo-Synephrine®
hydrochloride

Prompt and Prolonged Decongestion
Sinus Drainage and Aeration

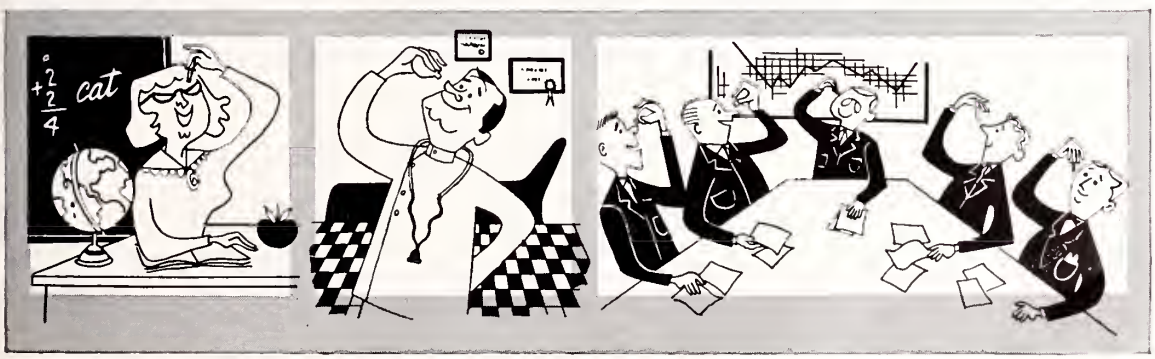
NO IRRITATION • NO SEDATION • NO EXCITATION

✻**Nasal Solutions** 0.25%, 0.5% and 1%
✻**Nasal Spray** 0.5%
✻**Pediatric Nasal Spray** 0.25%,
with Zephiran® chloride 1:5000,
antibacterial wetting agent and preservative
for greater efficiency

} *plastic, unbreakable squeeze bottle leakproof, delivers a fine mist*

Neo-Synephrine (brand of phenylephrine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U.S. Pat. Off.

Winthrop LABORATORIES
NEW YORK 18, N. Y. • WINDSOR, ONT.



W. I. POOLE, M. D.

Calvert City

1883 - 1955

Dr. Poole, 73, died Dec. 18 at the Illinois Central Hospital in Paducah.

A physician for 50 years, Dr. Poole had practiced at Calvert City for the past 14 years.

He was a courtesy staff member of the Western Baptist Hospital and a member of the Marshall County Health Board. He belonged to the Calvert City Methodist Church.

CARL BRENT WITT, M. D.

Louisville

1879 - 1956

Dr. Witt, a physician for 50 years, died at his home of a heart attack Jan. 9. He was 77.

A 1904 graduate of the Hospital College of Medicine in Louisville, Dr. Witt was a member of the Hardin County Medical Society, the AMA and the KSMA. He belonged to the Deer Park Baptist Church.

He practiced in Hardin, Meade and Breckenridge counties before coming to Louisville in 1925.

Pertinent Paragraphs

The Harvard School of Public Health recently announced its Scholarship Program for 1956-57. For information about the program, catalogues of the school, admission and scholarship applications and further information write the Secretary, Harvard School of Public Health, 55 Shattuck Street, Boston 15, Massachusetts.

The Hawaii Medical Association will celebrate its one hundredth anniversary April 22-29. The celebration will include a short professional program, a pageant, and a traditional Hawaiian feast with Polynesian entertainment. For reservations write the Hawaii Medical Association, 510 South Beretania St., Honolulu 13, Hawaii.

Hospital room rates in general hospitals in the United States have increased approximately five per cent in the past year, according to an announcement from the American Hospital Association. This report was based on 2,639 completed questionnaires from short term general hospitals in the United States and Canada.

CITY VIEW SANITARIUM

For the diagnosis and treatment of mental and nervous disorders, alcoholism and drug addictions

Established in 1907 by the late John W. Stevens, M. D.

52 acres near city. Separate buildings for men and women

Two full time psychiatrists

Electric shock and insulin therapy in selected cases

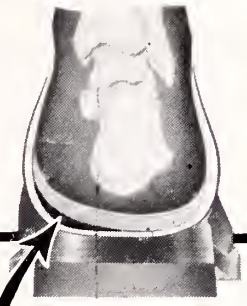
Occupational therapy

Physiotherapy department

Adequate laboratory facilities

NASHVILLE :—: TENNESSEE

Foot-so-Port Shoe Construction and its Relation to Weight Distribution



- Insole extension and wedge at inner carner of heel where support is most needed.
- Special Supreme rubber heels are langer than most anatomic heels and maintain the appearance of normal shaes.
- The patented arch suppart construction is guaranteed not to break down.
- Innersales are guaranteed not to crack, curl, or collapse. Insulated by a special layer of Texan which also cushions firmly and unifarmly.
- Foot-so-Part lasts were designed and the shae canstructian engineered with arthapedic advice.
- NOW AVAILABLE! Men's conductive shoes. N.B.F.U. specifications. For surgeons and operating room personnel.
- By a special process, using plastic pasitive casts of feet, we make mare custam shaes for polio, club feet and all types af abnarmal feet than any other manufacturer.

Write for detoils or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

unique
in successfully fighting
malpractice charges

**PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899**

LOUISVILLE Office:

Calvin Bimer, Rep.,

Telephone Clay 3636

Physicianss—Patronize your advertisers for they support the Journal.

FOR THE OFFICE OF DISTINCTION—IT'S HAMILTON'S NUTONE SUITE



Here are the most carefully selected woods; rich and durable uphosteries; satin brass drawer pulls, knobs and hardware; and strong construction.

Always the first choice of those who wisely invest in career long satisfaction.

See this and other Hamilton suites in our showroom.

The Crocker-Fels Company

Ask about our liberal financing plan

624 S. THIRD ST. CLay 8855 LOUISVILLE, KY.

SECLUSION MATERNITY



FAIRMOUNT HOSPITAL

FOR UNMARRIED GIRLS

Est. 1909

Private sanitarium with certified obstetrician in charge. All adoptions arranged through juvenile court. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

Write for Information

MRS. EVA THOMPSON

4911 East 27th St.

Kansas City, Mo.

WANTED: Registered physical therapist, by Kentucky Rehabilitation Center at the University of Kentucky, Lexington, Kentucky. Contact Medical Director at Kentucky Rehabilitation Center, Inc., at the University of Kentucky or call Lexington 2-2200, Ext. 2401 for appointment.

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465 **WAbash 6725**
334 W. BROADWAY
LOUISVILLE, KENTUCKY

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) Practice Survey and Recommendations
( ) Financial Records and Reports
( ) Professional Management Service
( ) Long-Term Financial Planning
( ) Tax Returns
( ) Other:
( ) Centralized Bookkeeping (Statements to Patients)
( ) Pre-Collection Program
( ) Partnership Formation
( ) Sale of Practice
( ) Collections

OCULISTS' PRESCRIPTIONS EXCLUSIVELY

MUTH OPTICAL COMPANY

Prescription Opticians

We maintain our own manufacturing and grinding laboratory

665 S. 4th Brown Hotel Building Louisville 2

THE KEELEY INSTITUTE

DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction

REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Clearview

On The Kratzville Road

EVANSVILLE, IND.

TELEPHONE 5-6181

A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.

SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery

ELECTROENCEPHALOGRAPH—CLINICAL LABORATORY — EKG AND BMR EQUIPMENT — STEREOSCOPIC X-RAY—HYDROTHERAPY

Albert J. Crevello, M. D.

Diplomate, American Board of Psychiatry & Neurology, Inc.

MEDICAL DIRECTOR

WAYSIDE HOSPITAL

168 North Broadway
Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

APPROVED BY AMERICAN MEDICAL ASSOCIATION

STAFF

H. HALBERT LEET, M. D. — JOHN H. ROMPF, M. D.
CARL WIESEL, M. D. — IRVING A. GAIL, M. D.

EDWARD L. HOUCHIN, ADMINISTRATOR

Phone: 2-2050

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)

(The Pioneer Postgraduate Medical Institution in America)

UROLOGY

A combined full-time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and patholog ; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anes thesia (cadaver); office g necology; proctological diagnosis; the use of the ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and s philology; neurologic physical medicine; continuous instruction in cysto-endoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as endoscopic prostatic resection.

PROCTOLOGY and GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; pathology, radiology, anatomy, operative proctology on the cadaver, anesthesiology, witnessing of operations, examination of patients preoperatively and postoperatively in the wards and clinics; attendance at departmental and general conferences.

For Information about these and other courses Addresss **THE DEAN, 345 WEST 50th St., New York 19, N. Y.**

NEW CASTLE SANITARIUM

Telephone 3621
NEW CASTLE, KY.

For the core of
CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the Americon Hospital Associotion
Member of the Americon Assn. of Nursing Homes
Licensed ond Approved by the Stote of Kentucky

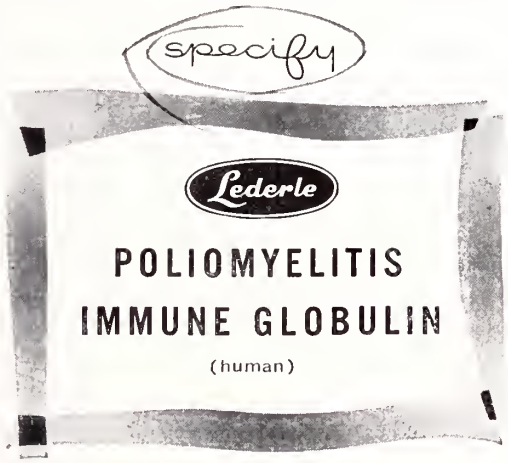
SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE

PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS

24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES
New Selectemp Moduloted Steom Heot With Filtered Air For Moximum Comfort ond Sofety
Protected Throughout With Automotic Fire Detection ond Alorm System

IRA O. WALLACE, Administrotor



For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

the most complete optical service in kentucky

Southern Optical COMPANY

Since 1897

4th and Chestnut
334 W. Broadway
LOUISVILLE

GUILD OPTICIANS

OVER 3 MILLION FACTS

IN THE NEW EIGHTEENTH EDITION

DATA ON 219,677 PHYSICIANS

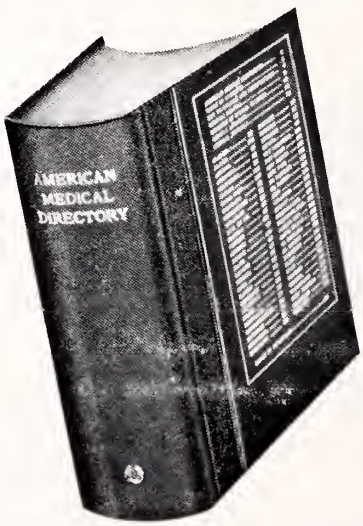
Physicians grouped alphabetically by cities and states, with year of birth; school, year grad.; state license; military service; whether diplomate of Natl. Board of Med. Examiners, or certified by one of examining boards in med. specialties; home, office addresses; member special society; medical school professorship.

LICENSING AND EXAMINING BOARDS, HEALTH OFFICERS

Shows State Board of Med. Examiners for each state; personnel of Natl. Board of Med. Examiners; educ. requirements of applicants, plan of Natl. Board examinations. Also Examining Boards in Med. Specialties; lists of Health Officers—state, district, county, city.

MEDICAL LAWS; JOURNALS; LIBRARIES

Medical Practice Act, Digest of Law and Board Rulings. Requirements for examination and reciprocity, grounds for refusing, revoking or suspending a license, penalties for violation of the Act. Also fees for licensure, dates of meetings, name and address of executive officer.



American Medical Association
535 N. Dearborn St., Chicago 10

369 medical libraries, with addresses, number volumes, names of librarians. 246 medical journals listed.

FACTS ON 7,482 HOSPITALS

Listing all recognized hospitals and sanatoriums of each state—name and address, year established, type of service; number of beds; how controlled; whether approved for general internship and residencies in specialties; director's name.

ALPHABETICAL INDEX OF PHYSICIANS

All physicians are alphabetically listed by name, with city location.

MEDICAL SCHOOLS

Existing and extinct, arranged chronologically under state. A general descriptive section shows all schools geographically, with history, location, name of dean.

MEDICAL SOCIETIES

Members of special societies grouped geographically, classified by related interests in seven groups. Names of nearly 150 societies shown.

18th Edition **AMERICAN MEDICAL DIRECTORY** Price $25.00



HydroCortone® -T B A

(HYDROCORTISONE TERTIARY-BUTYLACETATE, MERCK)

gives the arthritic patient more days of freedom from joint symptoms—in many patients the anti-rheumatic effect persists 2 to 10 times longer than after injection of hydrocortisone acetate. Its action is local and without systemic effect.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

SUPPLIED: SALINE SUSPENSION HYDROCORTONE-TBA—25 MG./CC., VIALS OF 5 CC.

introducing...



the latest addition to **AMA's** parade of **PR** aids

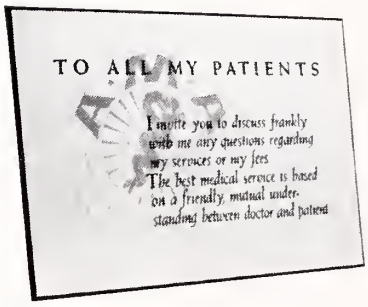
sure to make a hit with your patients by providing written answers to many questions about their medical care.

AMA now offers you its newest publication designed as a PR adjunct to your medical practice. TO ALL MY PATIENTS is just one of several public relations pieces recently developed by AMA to help you and your patients achieve that mutual understanding so important to a successful doctor-patient relationship. This attractive 12-page pamphlet—which was mailed to all AMA members—briefly describes the responsibilities of various persons on the medical team . . . discusses medical and hospital fees and health insurance . . . and encourages a friendly discussion of medical services and fees.

TO ALL MY PATIENTS begins: "I appreciate the confidence you have expressed in me by selecting me as your physician. I sincerely hope that I can give you and your family the kind of medical service you desire. . ."

TO ALL MY PATIENTS concludes: "It is difficult for a physician briefly to explain every service necessary in providing good care because each case is different. I sincerely hope this leaflet will give you a better understanding of some of the services you may require. . ."

For that added personal touch, space has been provided on the back cover for you to imprint or stamp your name. Quantities of TO ALL MY PATIENTS may be secured free of charge from the American Medical Association by sending in the coupon below.



a companion PR aid

TO ALL MY PATIENTS plaque for display in the office or reception room . . . encourages patients to ask questions about medical services or fees . . .

available from AMA for one dollar postpaid.

Send in the coupon today!

another A·M·A membership service

ORDER NOW

Public Relations Department
AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street • Chicago 10, Illinois

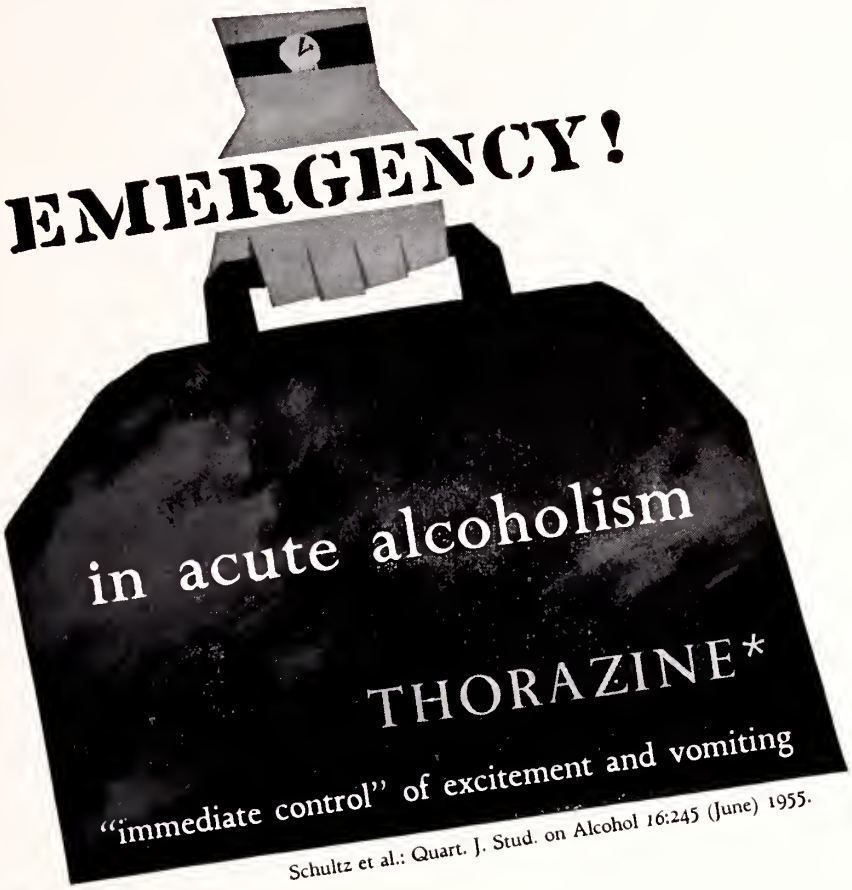
Send me_____TO ALL MY PATIENTS pamphlets

Also send_____office plaques at $1.00 each

NAME_____
(*please print*)

ADDRESS_____

CITY_____ZONE____STATE_____



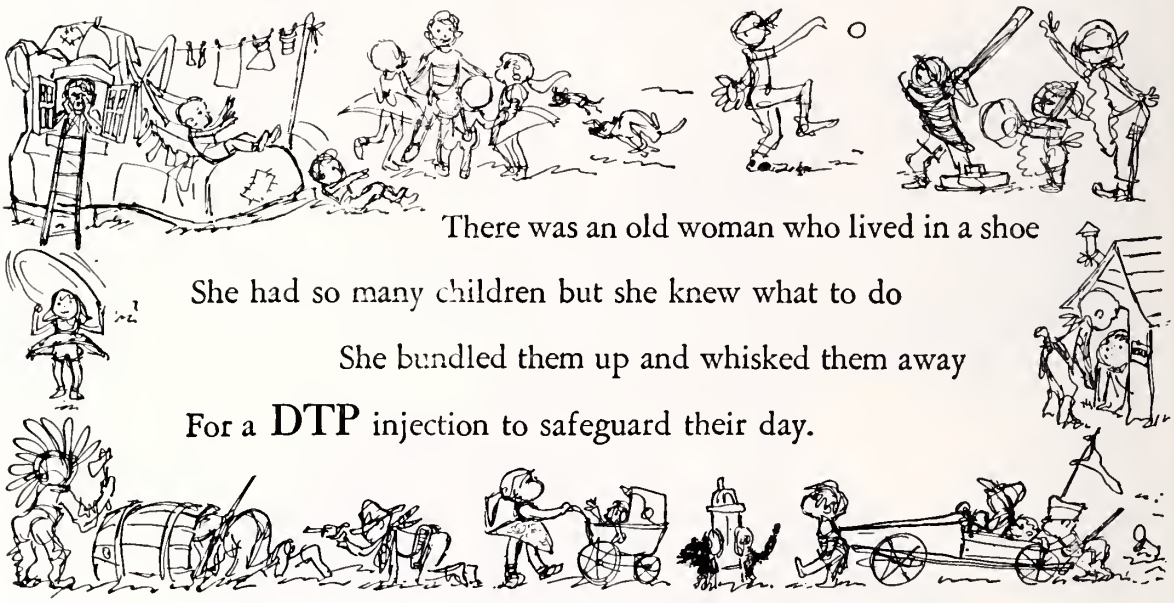
'Thorazine' is available in ampuls, tablets and syrup, as the hydrochloride; and in suppositories, as the base.

'Thorazine' should be administered discriminately; and, before prescribing, the physician should be fully conversant with the available literature.

for emergencies—always carry 'Thorazine' Ampuls in your bag

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.



- **One complete immunization**
- **99% of nonspecific protein removed**

DTP DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE COMBINED. Alum Precipitated or Plain.

- **Meets most rigid specifications**
- **Freedom from tissue irritation**
- **Maximum antigenicity with minimum of untoward reactions**

Additional products in The National Drug Company's most complete line of biologicals.

TETANUS ANTITOXIN
INFLUENZA VIRUS VACCINE, POLYVALENT
SMALLPOX VACCINE
GAS GANGRENE ANTITOXIN, TRIVALENT
TETANUS-GAS GANGRENE ANTITOXIN, POLYVALENT

☆ LEADING PRODUCERS OF BIOLOGICALS ☆

Tetanus Toxoid, Alum Precipitated or Plain. Diphtheria Antitoxin. Diphtheria Toxin for Schick Test. Diphtheria Toxoid, Alum Precipitated or Plain. Diphtheria and Tetanus Toxoids, Alum Precipitated. Pertussis Vaccine, Alum Precipitated or Plain. Rabies Vaccine. Rhus Tox Antigen. Typhoid Vaccine. Typhoid-Paratyphoid Vaccine. Catarrhalis Combined Vaccine for prophylaxis and treatment of the bacterial complications of the common cold. Staphylococcus-Toxoid-Vaccine Vatox. Strepto-Combined Vaccine. Strepto-Staphylo Vatox. Yellow Fever Vaccine.

Established for Highest Quality

Careful selection and processing of all ingredients under supervision of leading bacteriologists guarantees uniformly high potency, purity and efficacy of each product. Minimum of untoward reactions.

Complete directions, including dosage, route and technique of administration, precautions and contraindications if any, are given in the individual package inserts which accompany each product.

A supply of records of immunizations and tests are available to physicians on request.

PRODUCTS OF ORIGINAL RESEARCH

NATIONAL NATIONAL NATIONAL NATIONAL NATIONAL NATIONAL

THE NATIONAL DRUG COMPANY PHILADELPHIA 44 PA

New Evidence

again demonstrates the antihypertensive value of

Rauwiloid®

THE ORIGINAL ALSEROXYLON

Rauwiloid® / *In Mild Labile Hypertension*

Up to 80% of mild hypertensives respond[1]...and with less danger of depression[2] than with single alkaloidal preparations.

Easy to prescribe...uncomplicated dosage...two 2 mg. tablets at bedtime.

Rauwiloid® + Veriloid® / *In Moderate to Severe Hypertension*

Single-tablet medication combines 3 mg. Veriloid (alkavervir), a potent hypotensive agent noteworthy for its safety,[3] with 1 mg. Rauwiloid. High efficacy from lower Veriloid dosage, with greatly reduced side actions to Veriloid. Initial dose, one tablet t.i.d., p.c.

Rauwiloid® + Hexamethonium / *In Severe, Otherwise Intractable Hypertension*

Combines ganglionic blockade action of hexamethonium chloride dihydrate (250 mg. per tablet) with Rauwiloid (1 mg.) in a single tablet for easier, safer, ambulatory management of severe cases. Initial dose, ½ tablet q.i.d.

1. Moyer, J.H., in discussion of Galen, W.P., and Duke, J.F.: Outpatient Treatment of Hypertension with Hexamethonium and Hydralazine, South. M.J. *47*:858 (Sept.) 1954.

2. Moyer, J.H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

3. Wilkins, R.W.; Stanton, J.R., and Freis, E.D.: Essential Hypertension. Therapeutic Trial of Veriloid, a New Extract of Veratrum viride, Proc. Soc. Exper. Biol. & Med. *72*:302 (Nov.) 1949.

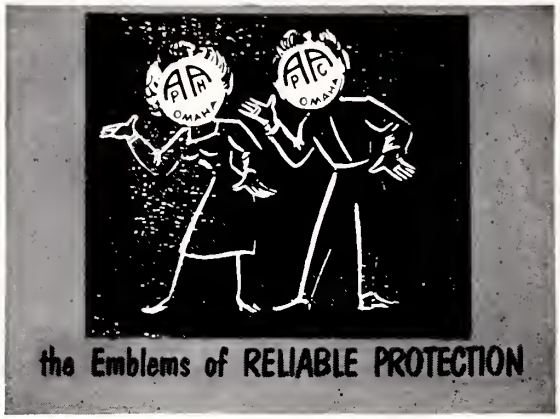
When Angina Complicates Hypertension

Pentoxylon®

Each long-acting tablet contains 1 mg. Rauwilaid and 10 mg. pentaerythritol tetranitrate (PETN). Lessens incidence and severity of attacks, avercames tachycardia, calms fear and tensian. Lawers elevated, but not narmal blaod pressure. Dasage: ane to twa tablets q.i.d., befare meals and on retiring.

Riker LOS ANGELES

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your eligible dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

BUYERS' GUIDE

Journal of the Kentucky State Medical Association, February, 1956

Abbott Laboratories 198, 199
American Medical Association 188
Ayerst Laboratories 178
Baker Laboratories, Inc. 124
Brayten Pharmaceutical Co. 121
Brown & Williamson Tobacco Co.....194
Burroughs Wellcome & Co.....179
Ciba Pharmaceutical Co. 175
City View Sanitarium 182
Clearview Sanitarium 184
The Coca-Cola Company 174
Crocker-Fels Company 183
Fairmount Hospital 184
Foot-So-Port-Shoe Company.....183
Geigy Pharmaceutical Company 195
General Electric X-Ray Dept. 126
Chas. B. Knox Gelatine Company.....117
Ernest Joky (Want Ad) 184
The Keeley Institute 184
Lakeside Laboratories 119
Lederle Laboratories 152, 153, 185
Eli Lilly & Company 130
W. R. Long (Insurance Company)....118
Louisville Medical Dental Business Bureau 184
Mead Johnson & Company 200
Medical Protective Company 183
Muth Optical Company 184
National Drug Company 190
New Castle Sanitarium 185
N. Y. Polyclinic Med. Sch. & Hosp.....185
Parke, Davis & Company.....106, 107
Pfizer Laboratories 113, 197
Physicians Casualty Insurance Co.....192
Pleasant Grove Hospital 180
Professional Building Association 120
Riker Laboratories 191
Schering Corporation....110, 111, 128, 129
Scientific Exhibits 154
Clayton L. Scroggins & Associates....176
G. D. Searle & Company.....173
Sharp & Dohme.....109, 123, 187
Smith, Kline & French Laboratories...189
Southern Optical Company.....186
E. R. Squibb & Company.....193
Upjohn Company 125, 177
U. S. Vitamin Corporation.....114, 115
Wayside Hospital 185
White Cross Hospital 196
Winthrop Laboratories, Inc.....181
Wyeth, Incorporated 127

the efficacy and safety of
Pentids have been confirmed
by clinical experience in
many millions of patients

Pentids

Squibb 200,000 Units Penicillin G Potassium

tablets (buffered)
bottles of 12 and 100

capsules (unbuffered)
bottles of 24 and 100
for infants and children

SQUIBB

"PENTIDS"® IS A SQUIBB TRADEMARK

What makes Viceroy different from other filter cigarettes?



The VICEROY filter tip contains 20,000 tiny filters made exclusively from pure cellulose . . . soft, snow-white, natural. This is twice as many filters as the other two largest-selling filter brands.

That is why VICEROY gives you such a fresh, clean taste—that real tobacco taste you miss in other filter brands. No wonder so many doctors now smoke and recommend King-Size VICEROYS.

If it's Viceroy you can tell the difference blindfolded!



King-Size Filter Tip **VICEROY**

in arthritis
and
allied disorders...



nonhormonal anti-arthritic

BUTAZOLIDIN®

(brand of phenylbutazone)

relieves pain • improves function • resolves inflammation

Employing the serum protein-polysaccharide ratio (PR) as an objective criterion of rheumatoid activity, it has again been shown that BUTAZOLIDIN "...produces more than a simple analgesic effect in rheumatoid arthritis."[1]

Clinically, the potency of BUTAZOLIDIN is reflected in the finding that 57.6 per cent of patients with rheumatoid arthritis respond to the extent of "remission" or "major improvement."[2]

Long-term study has now shown that the failure rate with BUTAZOLIDIN in rheumatoid arthritis, and particularly in rheumatoid spondylitis, is significantly lower than with hormonal therapy.[3]

(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. 1:168, 1955. (3) Halbrook, W. P.: M. Clin. North America 39:405, 1955.

BUTAZOLIDIN® (brand of phenylbutazone). Red coated tablets of 100 mg.

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before instituting therapy.

GEIGY PHARMACEUTICALS Division of Geigy Chemical Corporation
220 Church Street, New York 13, N. Y.
In Canada: Geigy Pharmaceuticals, Montreal

S11SS

Geigy

Adequate Hospitalization for Treatment of Alcoholics

Doctors find the modern facilities and specialized care available at White Cross Hospital meet a vital need.

Affords Sympathetic Atmosphere, Encouraging Personal Attention, Specially Trained Staff

It is generally believed that alcoholism is self-imposed. Often in general hospitals the alcoholic patient is not considered to be "legitimately" sick, which results in the wrong psychological and emotional atmosphere that aggravates the condition. This is why more and more doctors with alcoholic cases where hospitalization is essential are utilizing the facilities at White Cross Hospital, devoted to the treatment of alcoholics exclusively. Here a sympathetic, comfortable and pleasant atmosphere—so essential to rehabilitation—is assured. The White Cross staff, trained in the special problems of the inebriate, is adequate to assure prompt attention at all hours. The White Cross Hospital is under the direction of a competent licensed physician, with five consulting physicians subject to call. Registered nurses and technicians are in charge 24 hours daily.

Safe, Effective White Cross Treatment

A private hospital offering scientific, institutional, medical, psychological, reflex, reduction and other methods for the rehabilitation of consent patients suffering from alcoholism. With the consent of the doctor and patient, the regular White Cross procedure is followed. At your request, your patient remains entirely under your supervision. You may come and go in White Cross Hospital at will, and will find the staff completely cooperative. Your recommendations will be followed to the letter.

All equipment modern with facilities to take care of 50 patients both male and female.



Salem, Va. Hospital

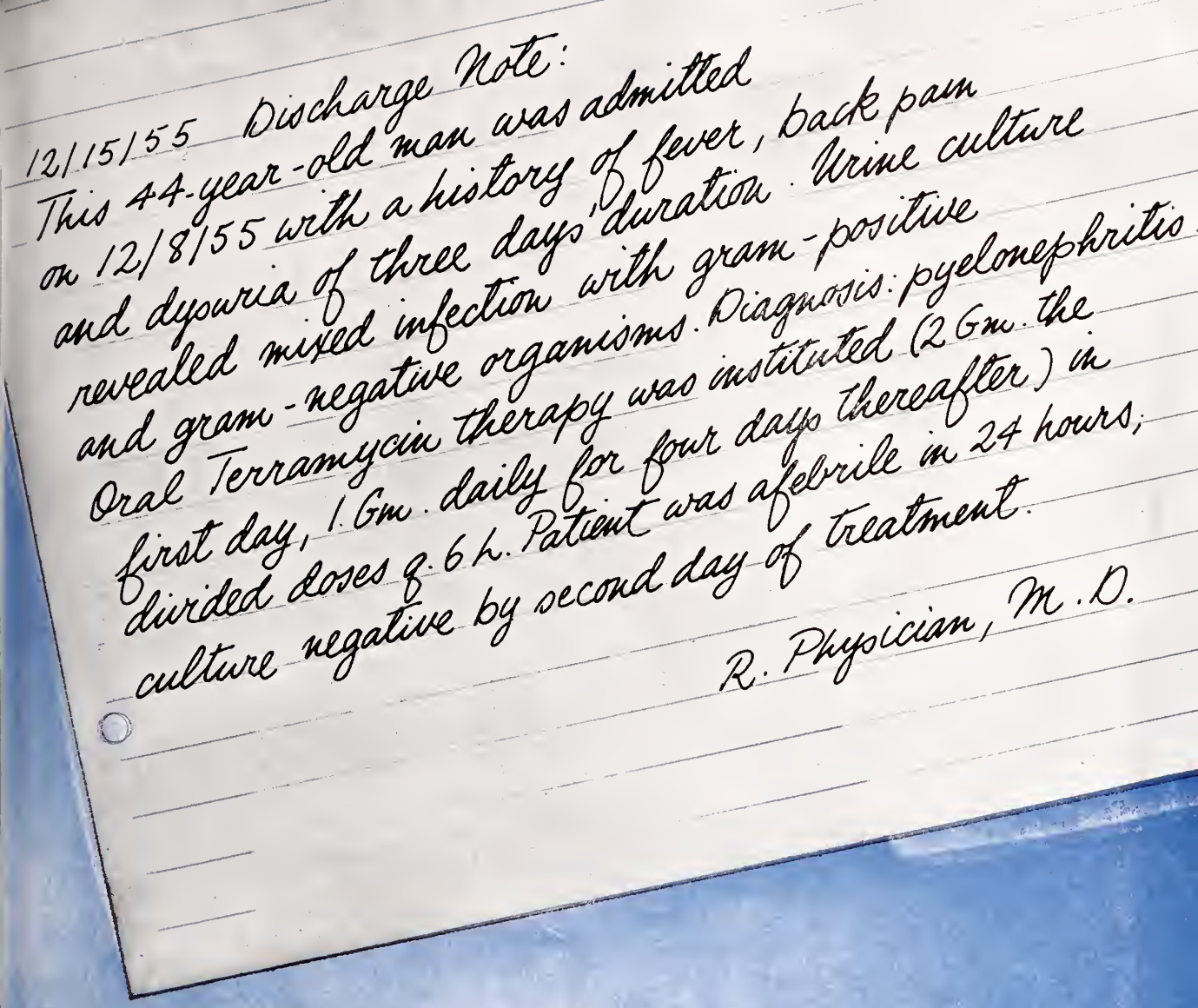
Approved and licensed by the Virginia State Hospital Board, Member American Hospital Association. Located atop beautiful Mt. Regis, in the quiet serene mountains of Virginia—conducive to rest, comfort and rehabilitation.

For information phone or write for booklet
Rates Reasonable

WHITE CROSS HOSPITAL

Five miles west of Roanoke on route No. 11
Salem, Virginia—Phone Salem 4761

Copyright 1955 H.N. Alford, Atlanta, Ga.



Your histories

are making medical history

in the golden age of antibiotic medicine

TERRAMYCIN®

Brand of oxytetracycline

Reports by thousands of physicians on millions of cases have built confidence in Terramycin as a well-tolerated, broad-spectrum antibiotic of choice—now finishing its sixth year of successful clinical use.

Pfizer PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.

Erythromycin in treatment of abscess

6/21/55

DISCHARGE SUMMARY

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

Communication to Abbott Laboratories.

ecific against
ccic infections

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that provides *specific therapy* against staph-, strep- or pneumococci. Since these organisms cause most bacterial respiratory infections (and since they are the very organisms most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe ERYTHROCIN when the infection is coccic?

filmtab®

Erythrocin®
(Erythromycin, Abbott)
STEARATE

th little risk of
ious side effects

Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to alter intestinal flora—with an accompanying low incidence of side effects. Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN (100 and 250 mg.), bottles of 25 and 100. Abbott

filmtab®

Erythrocin®
(Erythromycin, Abbott)
STEARATE

®Filmtab—Film sealed tablets; patent applied for.

Sick patients

need food for therapy

THAT MAN MUST EAT to remain well is a concept as old as medicine. But only recently has it been established (1) that nutritional needs are increased in illness; (2) that food sufficient to meet these needs is well utilized, and (3) that therapeutic nutrition prevents many of the debilitating effects of disease and injury.

Unfortunately, because of the anorexia accompanying illness, effective nutritional therapy requires added care on the part of the physician. Food comes from familiar kitchens and lacks the impressive aura of more dramatic therapeutic agents. Thus it is often difficult to convince the patient that food, too, is therapeutic —that although drugs may arrest disease only food can repair the ravages of disease.

Whatever the nutritional problem—whether caused by anorexia, mechanical difficulty in eating or limitation of gastric capacity or tolerance—only an assured food intake will solve it. The use of Sustagen, a food formulated for therapeutic nourishment, will overcome many difficulties in the therapeutic feeding of sick patients. A foundation for therapy thus may be established.

The development of Sustagen exemplifies the continuous effort of Mead Johnson & Company to provide the medical profession with products basic to the management of illness and the restoration of health.

Sustagen

Therapeutic Food for Complete Nourishment

Sustagen® is the only single food which contains all known nutritional essentials: protein, carbohydrate, fat, vitamins and minerals. It may be given by mouth or tube as the only source of food or to fortify the diet in brief or prolonged illness.

Sustagen

repairs tissue
restores appetite
overcomes asthenia

in

cirrhosis
peptic ulcer
geriatrics
infections
trauma
chronic disease

MEAD SYMBOL OF SERVICE IN MEDICINE

MEAD JOHNSON & COMPANY, EVANSVILLE 21, INDIANA, U.S.A.

CKS

The Journal
OF THE KENTUCKY STATE MEDICAL ASSOCIATION

VOL. 54 MARCH, 1956 NO. 3

COLLEGE OF PHYSICIANS OF PHILADELPHIA LIBRARY APR 16 1956

Contents

SCIENTIFIC ARTICLES

RETROPUBIC PROSTATECTOMY FOR THE BENIGN GLAND, N. Lewis Bosworth, M.D. 227
CLINICAL PARTITIONS IN PEDIATRICS, Frederic N Silverman, M.D. 229
AN OBLIQUE UPPER ABDOMINAL INCISION, Henry S. Collier, M.D. 234
THE USE OF CORTISONE IN AGED PATIENTS WITH ACUTE INFECTIONS, William A. Blodgett, M.D., James Robert Hendon, M.D., Lawrence T. Minish, Jr. M. D. 236
EYE INJURIES, Merrill J. Reeh, M.D. 240
THE CASE FOR SOCIAL MEDICINE, Peter L. Scardino, M. D. 246
ORAL SURGERY CASES OF INTEREST TO THE PHYSICIAN, Frank B. Hower, D.D.S. 249
A METHOD OF TREATMENT OF ALCOHOLISM AND THE RESULTS, William B. Terhune, M. D. 255
CASE DISCUSSIONS 261

SPECIAL ARTICLE

THE PEOPLE AND RURAL HEALTH 263

EDITORIALS

OBSTETRICS IN RURAL PRACTICE 265
FACTORS IN MEDICAL CARE 266

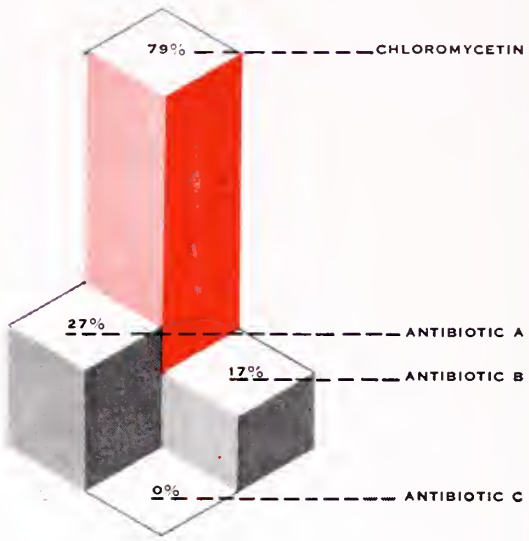
ORGANIZATION SECTION

Second Annual Senior Day is April 16 267
Dr. Teague Named Health Commissioner 267
Dr. Underwood Honored at Dinner 268
Ky. Academy of GP to Meet in April 269
April 1 is Deadline for KSMA Dues 270
Kentucky Surgeons to Meet May 19 270
Dr. Rowntree Wins National Award 271
State Health Board Elects Officers 271
Dr. Towery Joins Med. School Staff 271
Opposition to Nursing Bill Voiced 271
Medical Education Week Scheduled 272
Pediatrics Seminar Begins May 1 272

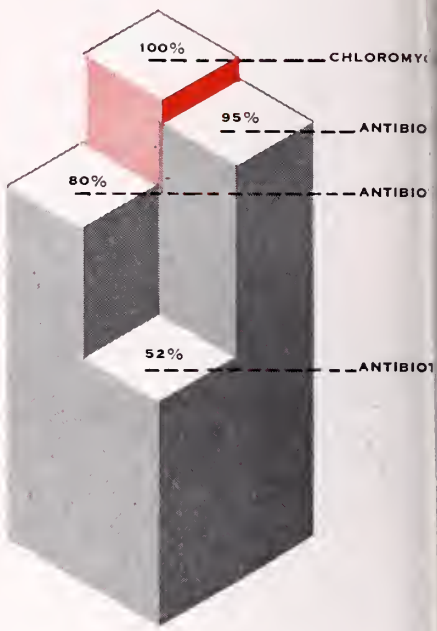
REGULAR DEPARTMENTS

President's Page 208, In the Books, 212, Washington News Digest 218, News Items 278, County Society Reports 281, In Memoriam 284

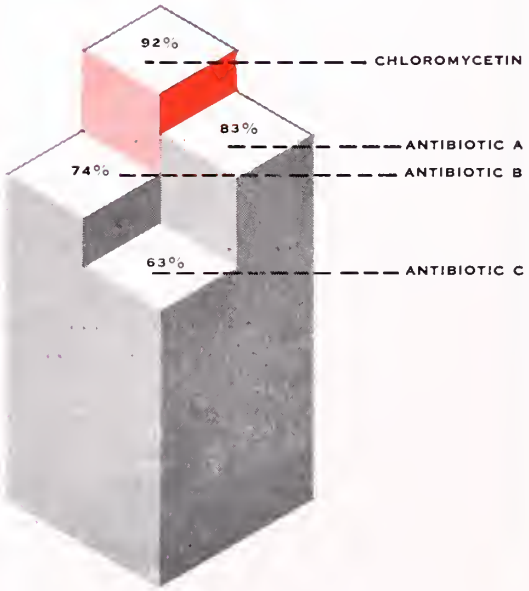
SENSITIVITY OF COMMON PATHOGENS TO CHLOROMYCETIN AND THREE OTHER MAJOR ANTIBIOTIC



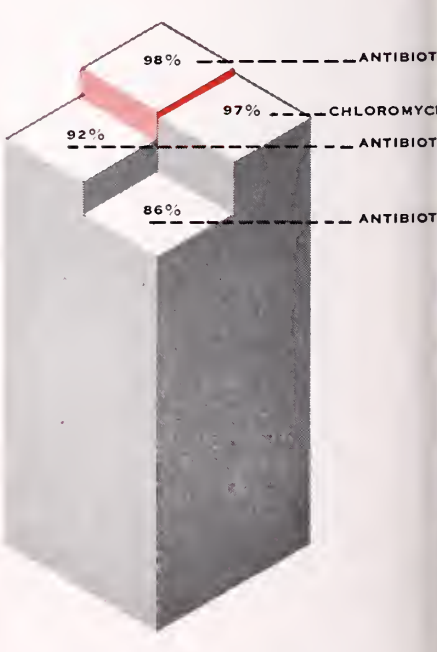
PROTEUS GROUP
(431-506 STRAINS)



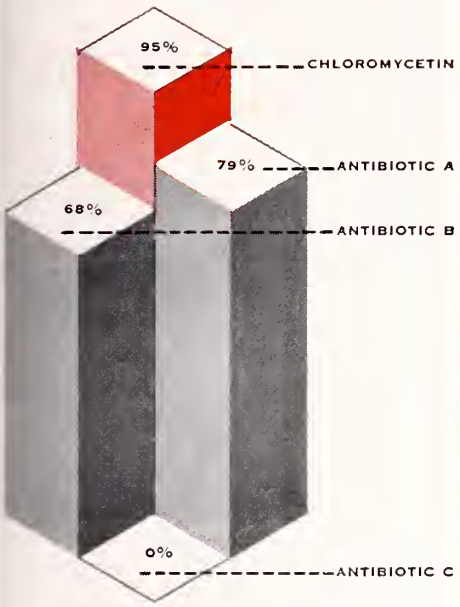
STREPTOCOCCUS VIRIDANS
(42-58 STRAINS)



NONHEMOLYTIC STREPTOCOCCUS
(109-141 STRAINS)



HEMOLYTIC STREPTOCOCCUS
(179-197 STRAINS)



AEROBACTER FECALIS
(14-21 STRAINS)

effective against more strains

Chloromycetin®

for today's problem pathogens

Resistant microorganisms frequently cause poor, delayed, or no response to antibiotic therapy. Because *in vitro* sensitivity tests are valuable guides in determining the antibiotic most likely to produce optimal clinical response, it is important that such tests be employed whenever possible. Recent clinical and laboratory studies[1-12] show that CHLOROMYCETIN (chloramphenicol, Parke-Davis) is effective against more strains of microorganisms than other commonly used antibiotics.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyserasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

references: (1) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305, 1955. (2) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (3) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (4) Austrian, R.: *New York J. Med.* 55:2475, 1955. (5) Murphy, F. D., & Waisbren, B. A., in Murphy, F. D.: Medical Emergencies: Diagnosis and Treatment, ed. 5, Philadelphia, F. A. Davis Company, 1955, p. 557. (6) Felshin, G.: *J. Am. M. Women's A.* 10:51, 1955. (7) Kass, E. H.: *Am. J. Med.* 18:764, 1955. (8) Tebrock, H. E., & Young, W. N.: *New York J. Med.* 55:1159, 1955. (9) Stein, M. H., & Gechman, E.: *New England J. Med.* 252:906, 1955. (10) Branch, A.; Starkey, D. H.; Rodgers, K. C., & Power, E. E., in Welch, H., & Marti-Ibáñez, F.: Antibiotics Annual, 1954-1955, New York, Medical Encyclopedia, Inc., 1955, p. 1125. (11) Munroe, D. S., & Cockcroft, W. H.: *Canad. M. A. J.* 72:586, 1955. (12) Norris, J. C.: *M. Times* 83:253, 1955.

h is adapt-
o Altemeier,
on, Sher-
e, Elstun,
It repre-
second and
g part of
ented in a
ssue.

MEDICAMENTA VERA

PARKE, DAVIS & COMPANY
DETROIT, MICHIGAN

The JOURNAL of the

Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR PRO TEM: W. B. TROUTMAN, M. D. MED. EDITORIAL EDITOR: S. A. OVERSTREET, M.D.
MANAGING EDITOR: J. P. SANFORD BOOK REVIEW EDITOR: WALTER S. COE, M.D.
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D. ORGANIZATION EDITOR: BARBARA N. MORGAN
CASE DISCUSSIONS EDITOR: J. C. BELL, M.D. PUBLISHER: J. G. DENHARDT, BOWLING GREEN

ADVISORY COMMITTEE TO THE EDITOR

Richard J. Rust, M. D. Guy Aud, M. D., Chairman James E. Hix, M. D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1958	Term Expires July 1, 1957	Term Expires July 1, 1956
Henry B. Asman, M.D.	Carey C. Barrett, M.D.	Everett H. Baker, M.D.
Richard Elliott, M.D.	Joe Bush, M.D.	John L. Dixon, M.D.
Rankin Blount, M.D.	Allen E. Grimes, M.D.	George G. Greene, M.D.
Marion F. Beard, M.D.	Richard F. Grise, M.D.	R. Arnold Griswold, M.D.
Glenn Bryant, M.D.	Billy Keller, M.D.	O. Leon Higdon, M.D.
Douglas Scott, M.D.	A. J. Miller, M.D.	James M. Keeton, M.D.
William C. Buschemeyer, M.D.	Robert Reeves, M.D.	Frank Moore, M.D.
Harry D. Abell, M.D.	Charles R. Yancey, M.D.	Alvin C. Poweleit, M.D.

Editorial and Business Offices, 620 S. Third St., Louisville, Kentucky

Subscription $8.00 per year Single Copy .80

KENTUCKY STATE MEDICAL ASSOCIATION OFFICERS—1955-56

Gant Gaither, 109½ East 7th Street, Hopkinsville ..... President
Richard R. Slucher, Buechel ..... President-Elect
Clyde C. Sparks, M.D., Mayo Arcade Ashland ..... Immediate Past President
Everett Baker, 408 Brown Bldg., Louisville ..... Vice-President
Nathaniel Bosworth, 117 S. Ashland, Lexington ..... Vice-President
Howell J. Davis, 330½ Allen, Owensboro ..... Vice-President
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Secretary-Editor Pro tem
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Treasurer
Charles A. Vance, 271 W. Short Street, Lexington ..... Speaker—House of Delegates
E. W. Jackson, 333 Broadway, Paducah ..... Vice Speaker—House of Delegates
J. Vernon Pace, 709-10 Citizen's Bank Bldg., Paducah ..... Chairman of the Council
Delmas M. Clardy, Hopkinsville ..... Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan	1956
Alternate to be Appointed	1956
W. Vinson Pierce, 33 E. Seventh St., Covington	1957
Leon Higdon, 333 Broadway, Paducah, (Alternate)	1957

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Building, Paducah	1956
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1958
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Carlisle Morse, 3612 Lexington Road, Louisville	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1958
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1957
Ninth District	J. M. Stevenson, Brookville	1958
Tenth District	J. Farra Van Meter, 183 N. Upper Street, Lexington	1958
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1958
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Charles B. Stacy, Pineville	1957

Entered as second-class matter, Oct. 22, 1906, at the Post Office at Bowling Green, Ky., under act of Congress, Mar. 3, 1897. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Throughout the world...

use in millions of cases

and reports by thousands

of physicians have built

confidence in TERRAMYCIN®

BRAND OF OXYTETRACYCLINE

...well-tolerated,
rapidly effective
broad-spectrum
antibiotic of choice.

Capsules, tablets,
taste-tempting liquid
forms and special
preparations for
parenteral, topical
and ophthalmic use.

Pfizer

Pfizer Laboratories
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, N. Y.

Erythromycin in treatment of pyoderma*

8/12/55

DISCHARGE SUMMARY

Patient, white female, age 39, entered hospital with a diagnosis of lymphoma, proved to be lymphosarcoma by biopsy.

Initially she was treated by X-ray radiation, adrenal cortical hormone and an antinauseant. During this regimen she developed a generalized rash which became infected. This was a drug reaction with infection due either to (1) scratching or (2) a low WBC count due to radiation. A number of boil-like lesions appeared over the body.

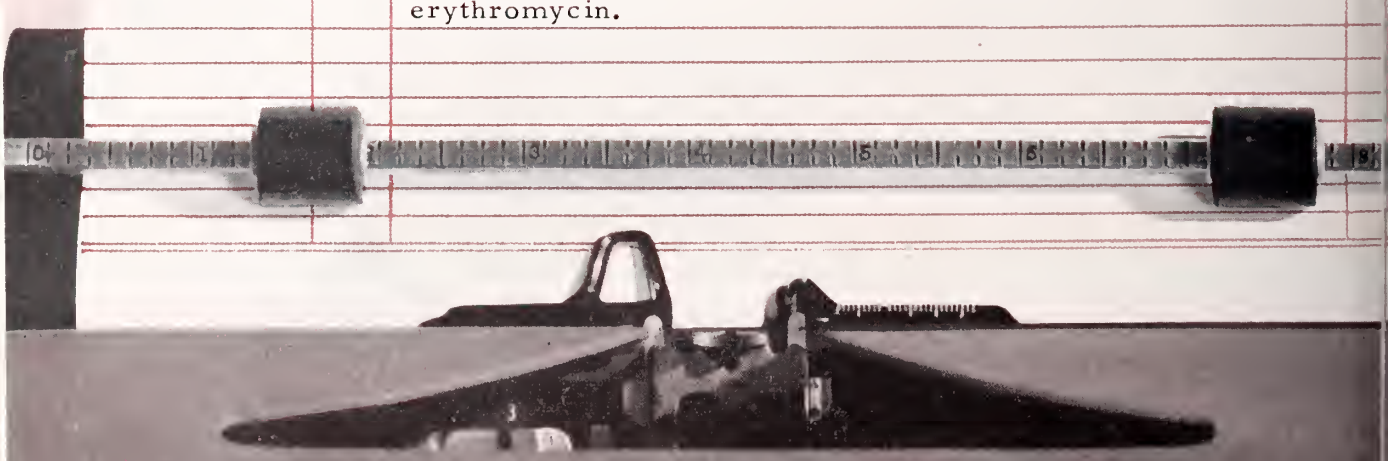
On 8/4 penicillin was started in a dosage of 600,000 units daily. Penicillin was continued for six days during which time the pyoderma became worse.

Aspirated material from the lesions yielded hem. S. aureus, coag. + and the following sensitivities were obtained: penicillin, more than 10 units; erythromycin, 10 mcg.; tetracycline, 50 mcg. When these results became available penicillin was discontinued.

On 8/9, erythromycin was started in a dosage of 200 mgm. q.i.d. Marked improvement was noted very soon and by 8/12 almost complete healing of all lesions had occurred. Patient was afebrile throughout.

Final Diagnosis: (1) lymphosarcoma (2) secondary pyoderma due to hemolytic Staphylococcus aureus.

Result: complete healing of secondary pyoderma with erythromycin.



*Communication to Abbott Laboratories

pecific against
occic infections

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that provides *specific therapy* against staph-, strep- or pneumococci. Since these organisms cause most bacterial respiratory infections (and since they are the very organisms most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe ERYTHROCIN when the infection is coccic?

filmtab®

Erythrocin®
(Erythromycin, Abbott)
STEARATE

with little risk of
erious side effects

Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to alter intestinal flora—with an accompanying low incidence of side effects. Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN (100 and 250 mg.), bottles of 25 and 100.

Abbott

filmtab®

Erythrocin®
(Erythromycin, Abbott)
STEARATE

®Filmtab—Film sealed tablets; patent applied for.

President's Page

The history of Kentucky medicine is filled with great accomplishments by physicians. The pioneers with the complex problems of family health, public health, transportation difficulties and care of the sick solved these problems in the face of obstacles that they recognized but repulsed.

Today, the problems have taken the form of legislation, organization, education, desegregation and socialistic trends. As the Norwegians refer to the North wind as the factor that made the Vikings strong so can we say that the winds of arduous tasks have given us strength.

The Councilors of our State Medical Association meet monthly or as often as required to work on the business of the moment and to make necessary decisions when the House of Delegates is not in session. The sincerity of these councilors, the quality of the discussions, the harmony after votes are taken and the effort to do all possible for a better State Association is impressive and a challenge to all of us.

There is an East, a West and a Central section of the State Medical Association. The care of the sick and the protection of health is our mission whether in the largest center in Jefferson County or in the most remote hillside of the East or West section. Sympathetic understanding of each other's problems is a goal that should engage our constant attention. Beneficial legislation and advantageous decisions will be our reward.

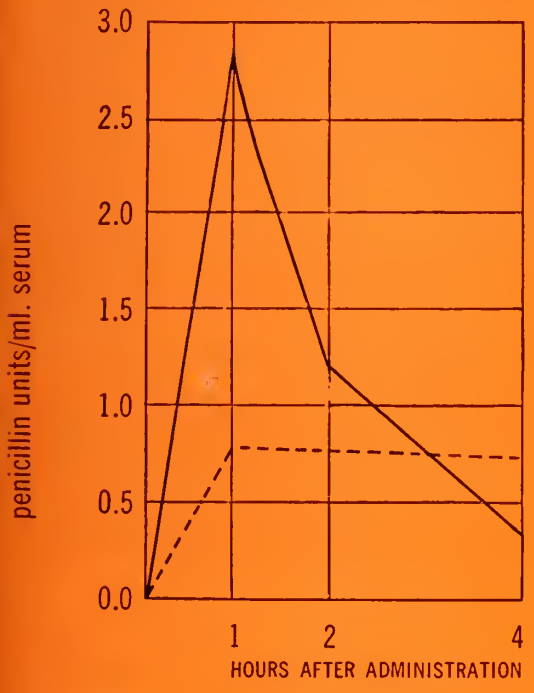
The Divine guidance that gave courage and direction to the pioneer is with us now as we move rapidly into 1956.

EVERETT BAKER, M. D.
Vice-President

ORAL PENICILLIN

WITH *INJECTION* PERFORMANCE

Now! A 500,000-unit tablet for higher, faster blood levels than from injected procaine penicillin



——— PEN·VEE·*Oral*, 500,000 units, one tablet, 19 subjects[1]

– – – – Procaine Penicillin G, 600,000 units, one injection, 10 subjects[2]

Supplied: PEN·VEE·*Oral* Tablets, 500,000 units, scored, bottles of 12; 200,000 units, scored, bottles of 36. Also available: BICILLIN*·VEE Tablets, 100,000 units of benzathine penicillin G and 100,000 units of penicillin V, bottles of 36.

1. Wright, W.W.: Personal communication.
2. Price, A.H.: Personal communication.

PEN·VEE·*Oral**

Penicillin V, Crystalline (Phenoxymethyl Penicillin)

Wyeth®

Philadelphia 1, Pa.

*Trademark

Meat...

and the Value of Fat in Nutrition

Authorities in the field of nutrition no longer consider fat as an optional component of the diet. Evidence from the laboratory and bedside indicates that fat in small amounts may be looked upon as an obligatory constituent of a health-promoting diet.[1]

The far-reaching value of fat in nutrition has been amply demonstrated in laboratory animals in its pronounced effect on growth, on pregnancy and lactation, on nitrogen-sparing action, on work capacity, on time of sexual maturity, on the period of survival during fasting, and on ability to combat external stresses.[1]

Young animals fed a fat-free diet not only fail to grow normally, but develop hair and skin changes characteristic of "essential" fatty acid deficiency.[2] Fatty acids other than the "essential" fatty acids also appear to be necessary for optimal health. Animals fed "essential" fatty acids but no others do not grow optimally.

The value of fat in human nutrition was emphasized in a recent study[2] comprising 200 patients incapable of receiving adequate nourishment. For periods of 1 to 30 days, these patients were given supplementary fat alimentation by vein in the form of fat emulsion containing "essential" as well as other fatty acids. The result was typically a marked increase in weight and more positive nitrogen and potassium balances.

Meat, recognized for its high content of biologically valuable protein, B vitamins, and essential minerals, provides, in addition, substantial amounts of nutritionally important fat.

1. Deuel, H. J., Jr.: Newer Concepts of the Role of Fats and of the Essential Fatty Acids in the Diet, Food Res. *20*:81 (Jan.-Feb.) 1955.

2. Meng, H. C.: Preparation, Utilization, and Importance of Neutral Fat Emulsion in Intravenous Alimentation, in Najjar, V. A.: Fat Metabolism, Baltimore, The Johns Hopkins Press, 1954, pp. 69-92.

The nutritional statements in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

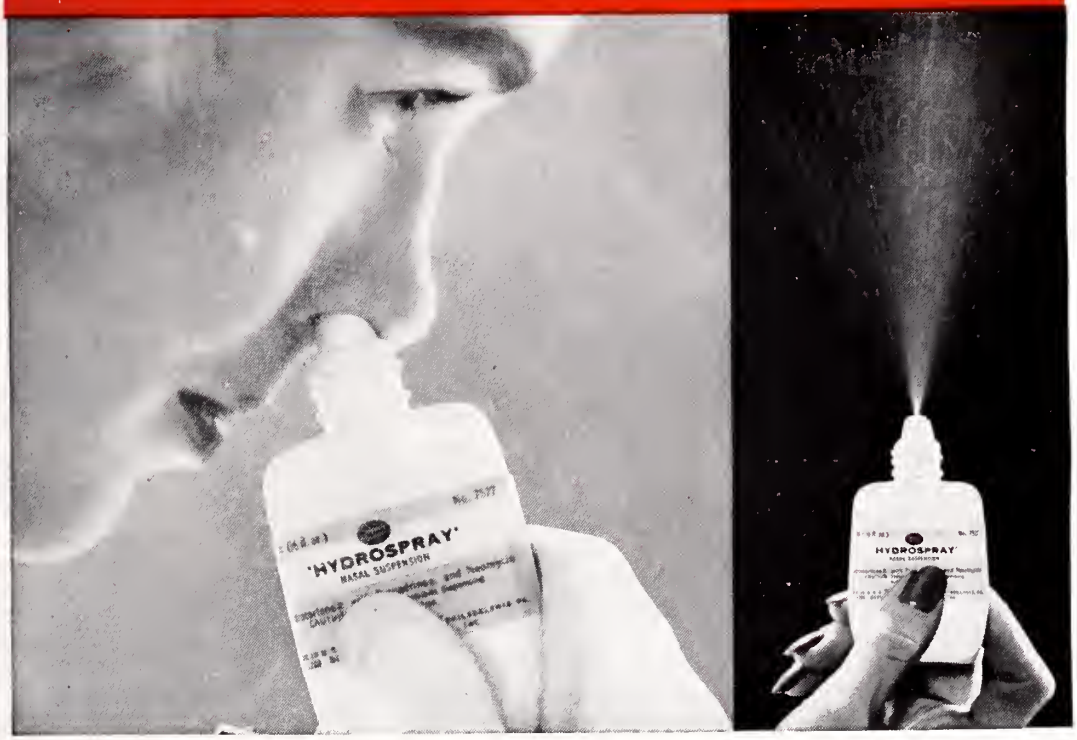
American Meat Institute
Main Office, Chicago . . . Members Throughout the United States

'Hydrospray' NASAL SUSPENSION

(HYDROCORTONE® WITH PROPADRINE® AND NEOMYCIN)

Anti-inflammatory—
Decongestant—Antibacterial

MAJOR ADVANTAGES: New synergistic anti-inflammatory, decongestant and antibacterial formula. High steroid content assures effective response.



Topically applied hydrocortisone[1] in therapeutic concentrations has been shown to afford a significant degree of subjective and objective improvement in a high percentage of patients suffering from various types of rhinitis. HYDROSPRAY provides HYDROCORTONE in a concentration of 0.1% plus a safe but potent decongestant, PROPADRINE, and a wide-spectrum antibiotic, Neomycin, with low sensitization potential. This combination provides a three-fold attack on the physiologic and pathologic manifestations of nasal allergies which results in a degree of relief that is often greater and achieved faster than when any one of these agents is employed alone.
INDICATIONS: Acute and chronic rhinitis, vasomotor rhinitis, perennial rhinitis and polyposis.

SUPPLIED: In squeezable plastic spray bottles containing 15 cc. HYDROSPRAY, each cc. supplying 1 mg. of HYDROCORTONE, 15 mg. of PROPADRINE Hydrochloride and 5 mg. of Neomycin Sulfate (equivalent to 8.5 mg. of neomycin base).

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.



TEXTBOOK OF ENDOCRINOLOGY—edited by Robert H. Williams, M. D.; Second Edition; 776 pages; W. B. Saunders Co.; Phila.; 1955. $13.00.

It requires more than a modicum of courage to bring out a textbook of endocrinology in these days. Our knowledge of this field of medicine, so long minimal, is increasing by leaps and bounds, and undergoing revision and changes. Concepts presented today may, in a short time, undergo marked modification, or be supplanted by other concepts reflecting newer information.

The authors and publishers of Robert Williams' second edition have done the best that could be done in such a situation. The first edition has been completely reviewed and revised, and the necessary mechanics, incident to publication, so expedited that many of the really new things in endocrinology are found between the covers.

The editor has enlisted the aid of outstanding authorities in the preparation of several sections of the book. The portion dealing with the testes, particularly, is presented in a simple and lucid manner. To single out one section however, by no means indicates any derogation of the others. All are presented in a form appealing to the student and the practitioner and in accordance with the consensus of current endocrine thought. There are many illustrations, some in color.

A perfectionist might question the inclusion of discussions of the use of hormones in disorders of non-endocrine nature. The physician will welcome the aid these provide to his therapeutic stockpile. More questionable is the inclusion of a chapter on obesity in a treatise on endocrinology. Such inclusion—though little fault is found with the argument presented—may serve to retain this subject in a field where it has no business.

One is conscious at times of a desire for more careful editing. There are instances of needless repetition, of inconsistency of recommendations in different parts of a given section. These are minor matters which may have been the result of a sincere attempt to bring to men of medicine new and authoritative information about endocrinology. This attempt has met with bright success.

James Robert Hendon, M. D.

PATHOLOGY FOR THE SURGEON—by William Boyd, M. D.; Seventh Edition; 737 pp., 547 illustrations; W. B. Saunders Co.; Philadelphia; 1955; $12.50.

Every surgeon must be conversant with surgical pathology to some degree, and of necessity must have available a reference text or two. Dr. Boyd has provided, in my opinion, the most readable text on surgical pathology in 30 years. The book is designed for the surgeon rather than the pathologist, but as a literary achievement, it can be recommended to everyone. The reader will not encounter the dreary details of morbid anatomy at the sacrifice of clinical correlation. The wit and warmth of the essayist leads the reader to explore each successivle chapter with enthusiasm, an unusual feature in pathology texts.

Dr. Boyd's book truly differs from those written on general pathology in that it deals with a future of disease and not the past. Pathology must be presented in a dynamic manner to be of greatest value to the surgeon.

Dr. Boyd may not endear himself to the oversensitive surgeon; his remarks are often blunt and unveiled. Thus his discussion of "chronic appendicitis" and "chronic mastitis" are examples of interesting reading material on two not so controversial subjects.

The illustrations are well chosen, and the reproduction is of excellent quality.

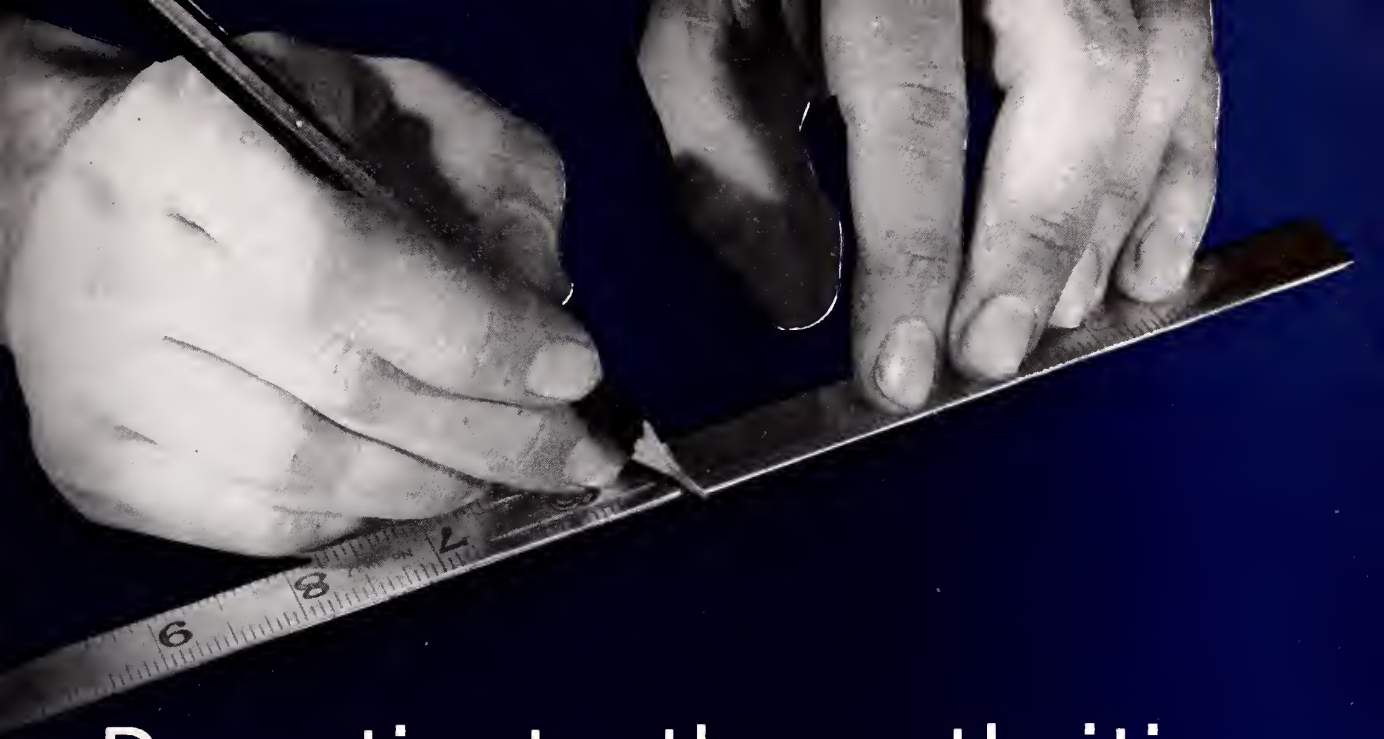
No book of 737 pages can cover such a vast subject as surgical pathology, and many of Dr. Boyd's discussions are too abbreviated to be of great value. The bibliography in many instances is incomplete and disappointing. However, for anyone with the price of the book and the time and inclination to use it, it should prove to be a valuable addition to his library.

William Christopherson, M.D.

PREVENTIVE MEDICINE IN WORLD WAR II; VOLUME II. ENVIRONMENTAL HYGIENE—from the Medical Department of the United States Army.

Military preventive medicine is based on the broad application of disease prevention to military conditions. A large factor in this is environmental hygiene. The development by the army of food management, housing, water purification, waste disposal, insect and rodent

(Continued on page 214)



Re-activate the arthritic

MOST POTENT ANTI-RHEUMATIC *

Sterane

Even where hydrocortisone, cortisone, and other agents had failed, prednisolone (STERANE) restored articular mobility and functional capacity to normal in rheumatoid arthritis.[1]

Four times more effective than hydrocortisone, and, on the basis of preliminary findings,[2,3] superior in potency even to prednisone (cortisone analog), STERANE is also relatively free of such hormonal side effects as edema, hypertension, or hypopotassemia.

Supplied: White, 5 mg. oral tablets, in bottles of 20 and 100. Pink, 1 mg. oral tablets, in bottles of 100. Both are deep-scored and in the distinctive "easy-to-break" size and Pfizer oval shape.

References: 1. Bunim, J. J., et al.: J.A.M.A. 157:311, 1955. 2. Forsham, P. H., et al.: Paper presented at First Internat. Conf. on Prednisone and Prednisolone, New York, May 31-June 1, 1955. 3. Perlman, P. L., and Tolksdorf, S.: Scientific Exhibit presented at A.M.A. Annual Meet., Atlantic City, June 6-11, 1955.

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

*brand of prednisolone

SOCIALIZED MEDICINE

May never come, but. . . Socialized Insurance is here to stay, and it has created a sizable Estate Handicap against the physician.

In the case of a young doctor with young children, this economic penalty may be as high as $40,000.00

But there is a solution, and the cost is no greater than the Social Security Tax. Write now for complete information

— — — — — — — — — —

W. R. LONG & ASSOCIATES

1534 Bardstown Road—Louisville, Ky.

Without obligation to me I would like to have more information about the solution to the Social Security problem of the young doctor. I am in good health and was

born .....
Month Day Year

Name.....

Address.....

IN THE BOOKS

(Continued from page 212)

control, and foreign quarantine under the great variety of conditions faced by our troops in the many lands to which they were disbursed in our late global war is one of the major accomplishments of the Medical Department.

In this volume the major activities of the Division of Sanitation and the Division of Sanitary Engineering of the Army Medical Department during World War II are reviewed from a historical as well as an operative viewpoint. An analysis is presented of those plans, operations and activities which utilized, modified or controlled environment for health purposes.

Evaluation of these experiences and the analysis of the condition, forces, circumstances and motivations and the plans and operations followed gives us a sound framework upon which to base future management of environmental hygiene. The failures as well as the successes have been recorded. The material was edited by a distinguished staff of eminent authorities in the field of preventive medicine. All of them held responsible positions in the Medical Department during the war.

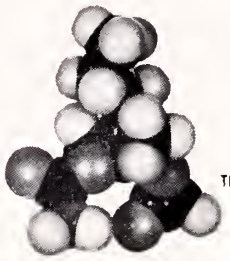
The book holds considerable interest and some nostalgia for those former medical officers who were directly involved in some of the problems. It will no doubt serve the army as a textbook on military sanitation and is a valuable reference book for medical and engineering school libraries

Asa Barnes, M. D.

The US Food and Drug Laws were fifty years old February 29. To celebrate the occasion, Abbott Laboratories of New York, held a commemorative dinner and program. Austin Smith, M. D., editor of the Journal of the American Medical Association, participated in a panel discussion entitled "50 Years' Progress Under Food and Drug Laws."

M and R. Laboratories, Columbus, Ohio, pioneers in the field of infant nutrition, recently changed its name to Ross Laboratories. The new name commemorates the name of Stanley Ross, one of the founders of the company. Announcement of the change was made by Harry C. Moores, chairman of the board.

Patronize the Advertisers in your Journal.



THE MILTOWN MOLECULE

Two articles in the April 30th issue of The Journal of the AMA[1,2] report on . . .

an entirely new type of tranquilizer with muscle relaxant action—orally effective in

ANXIETY, TENSION and MENTAL STRESS

- no autonomic side effects—well tolerated
- selectively affects the thalamus
- not related to reserpine or other tranquilizers
- not habit forming, effective within 30 minutes for a period of 6 hours
- supplied in 400 mg. tablets. Usual dose: 1 or 2 tablets—3 times a day

1. Selling, L. S.: J.A.M.A. **157:** 1594, 1955. 2. Borrus, J. C.: J.A.M.A. **157:** 1596, 1955.

Miltown®

the original meprobamate—2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate—U. S. Patent 2,724,720

DISCOVERED AND INTRODUCED by Wallace Laboratories, New Brunswick, N. J.

Literature and Samples Available On Request

What makes Viceroy different from other filter cigarettes?



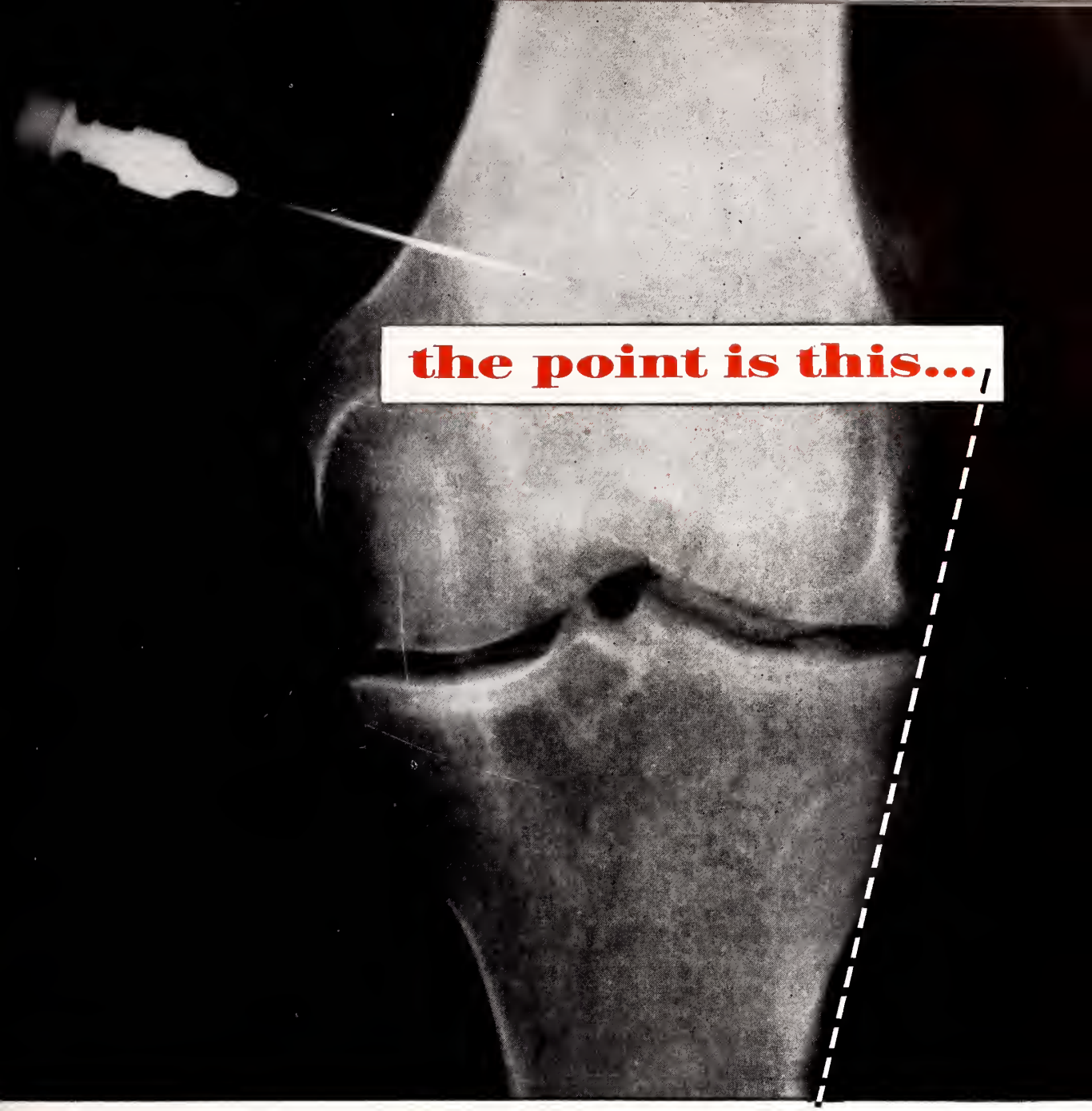
The VICEROY filter tip contains 20,000 tiny filters made exclusively from pure cellulose . . . soft, snow-white, natural. This is twice as many filters as the other two largest-selling filter brands.

That is why VICEROY gives you such a fresh, clean taste—that real tobacco taste you miss in other filter brands. No wonder so many doctors now smoke and recommend King-Size VICEROYS.

If it's Viceroy you can tell the difference blindfolded!



King-Size Filter Tip **VICEROY**



HydroCortone® -T B A

(HYDROCORTISONE TERTIARY-BUTYLACETATE, MERCK)

gives the arthritic patient more days of freedom from joint symptoms—in many patients the anti-rheumatic effect persists 2 to 10 times longer than after injection of hydrocortisone acetate. Its action is local and without systemic effect.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

SUPPLIED: SALINE SUSPENSION HYDROCORTONE-TBA—25 MG./CC., VIALS OF 5 CC.

WASHINGTON NEWS DIGEST

Washington, D. C.,—All too frequently overlooked in Congressional activity on health and related bills each year are the little-publicized but highly important appropriations measures —without which no program of the federal government could move forward. The appropriations hearings in the House (where all money bills must originate) rarely get headlines they are conducted behind closed doors. Weeks and some times months later, the hearings are published, but by then the bill supplying money for an agency has been reported to the House.

It's only when the measure gets to the Senate that private groups and individuals are heard—by then in open sessions. Closed House sessions are not new. That is the way it has been done ever since Congress set up a separate committee on appropriations back in 1865.

The importance of appropriations in running the federal government was clearly illustrated when the President submitted to Congress his 1,272-page budget message in which he sought $65.9 billion for all federal programs for the fiscal year beginning July 1.

While there was no overall total of projected spending by all the agencies in the health field, the budget requests for the Department of Health, Education, and Welfare showed a sharply upward trend. And if certain new legislation is voted on this session—like the projected 5-year program of construction grants for medical schools and private laboratory facilities—the total figure for subsequent years is likely to be even higher.

On the medical school-laboratory construction bill, the President asked Congress for $40 million for the first year (estimated cost over five years is $250 million). Construction grants, which would have to be matched on a 50-50 basis, would be available for private medical schools as well as non-federal laboratories conducting research into a wide range of crippling diseases.

The budget message also calls for another $30 million in outright grants, to the states to help them in financing poliomyelitis vaccination programs, the same amount appropriated by Congress last session. The administration in a separate request asked for extension of the polio law, from February 15, 1956 to June 30, 1957, and both the House and Senate with only brief debate voted the 17-month extension. Since only half of last year's $30 million was spent up to February 15 expiration date of the original act, there was no rush for Congress to act on the new account.

Other new spending asked by the administration, contingent, of course, on enabling legislation, includes $10 million for initial capitalization of mortgage loan guarantees for health facilities; $5 million for graduate and practical nurse and professional health personal training, $3 million for water pollution grants; $1.5 million for mental health expansion programs; and $1 million for sickness and disability surveys in the U.S.

If Congress approves the requests, virtually all segments of the Department of HEW will have more money to spend than in this fiscal year. None would benefit more, however, than the medical research arm of government, the National Institutes of Health. The total sought for the seven institutes in 28% more than estimated spending this year. Here are some examples: National Cancer Institute, $32,437,000, up 29%; National Heart Institute, $22,106,000, up 17%, and the National Institute of Allergy and Infectious Diseases (formerly the National Microbiological Institute), $9,799,000, a 26% increase.

The President requested $130 million for the Hill-Burton hospital-clinic construction program which will be 10 years old this August. In this connection Congress has been asked to extend the act for two years beyond next year, and action is expected this session.

NOTES:

After a study of possibilities in the peaceful uses of atomic energy, a panel has recommended, among other things, that the U. S. encourage states and private organizations to take full advantages of the opportunities offered by radioactive material for medical research and treatment.

It now appears that an improved and more uniform program of medical care for service families will be adopted this session—possibly before this is published. One feature: A $25 deductible charge in civilian hospitals, but with the government paying the full insurance premium, and a mandatory subsistence charge in military hospitals.

Making slower progress is the plan—under consideration for more than a year—for a health insurance program for U. S. civilian workers. Here the government would pay about half the cost.

Several committees are urging stricter penalties and other changes to bring the illicit narcotic traffic under better control; so far no suggestion of more controls over the medical profession in the handling of narcotics.

Upjohn

Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

Cortef* *tablets*

Supplied:

5 mg. tablets in bottles of 50
10 mg. tablets in bottles of 25, 100, 500
20 mg. tablets in bottles of 25, 100, 500

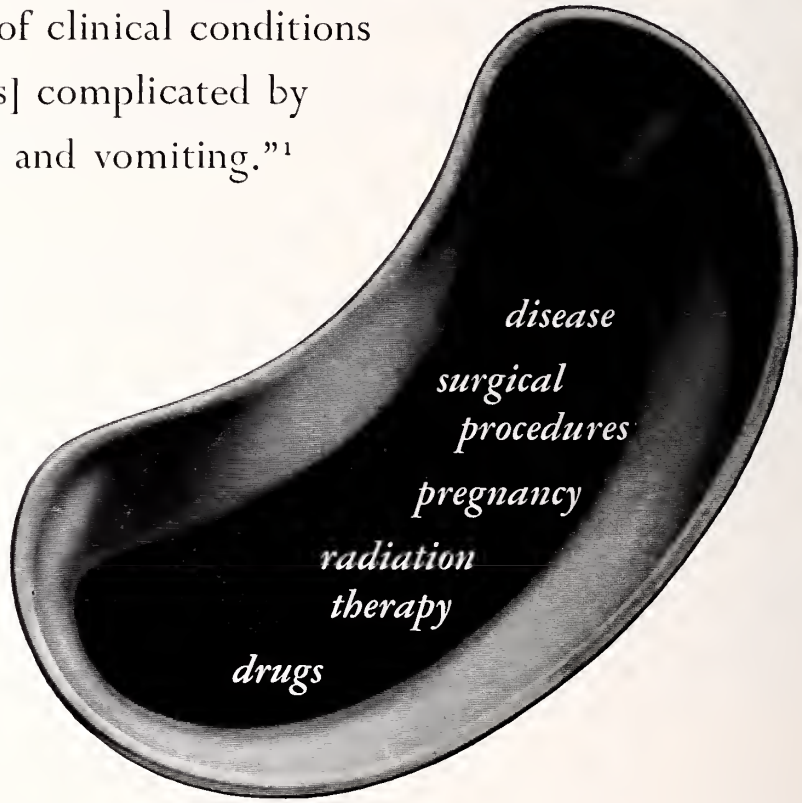
*REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF HYDROCORTISONE (COMPOUND F)

The Upjohn Company, Kalamazoo, Michigan



THORAZINE*

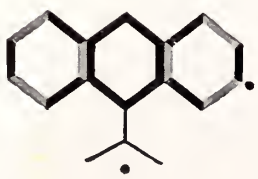
"An effective antiemetic agent for a wide range of clinical conditions [and situations] complicated by nausea and vomiting."[1]



1. Moyer, J.H., et al.: Arch. Int. Med. 95:202 (Feb.) 1955.

'Thorazine' is available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

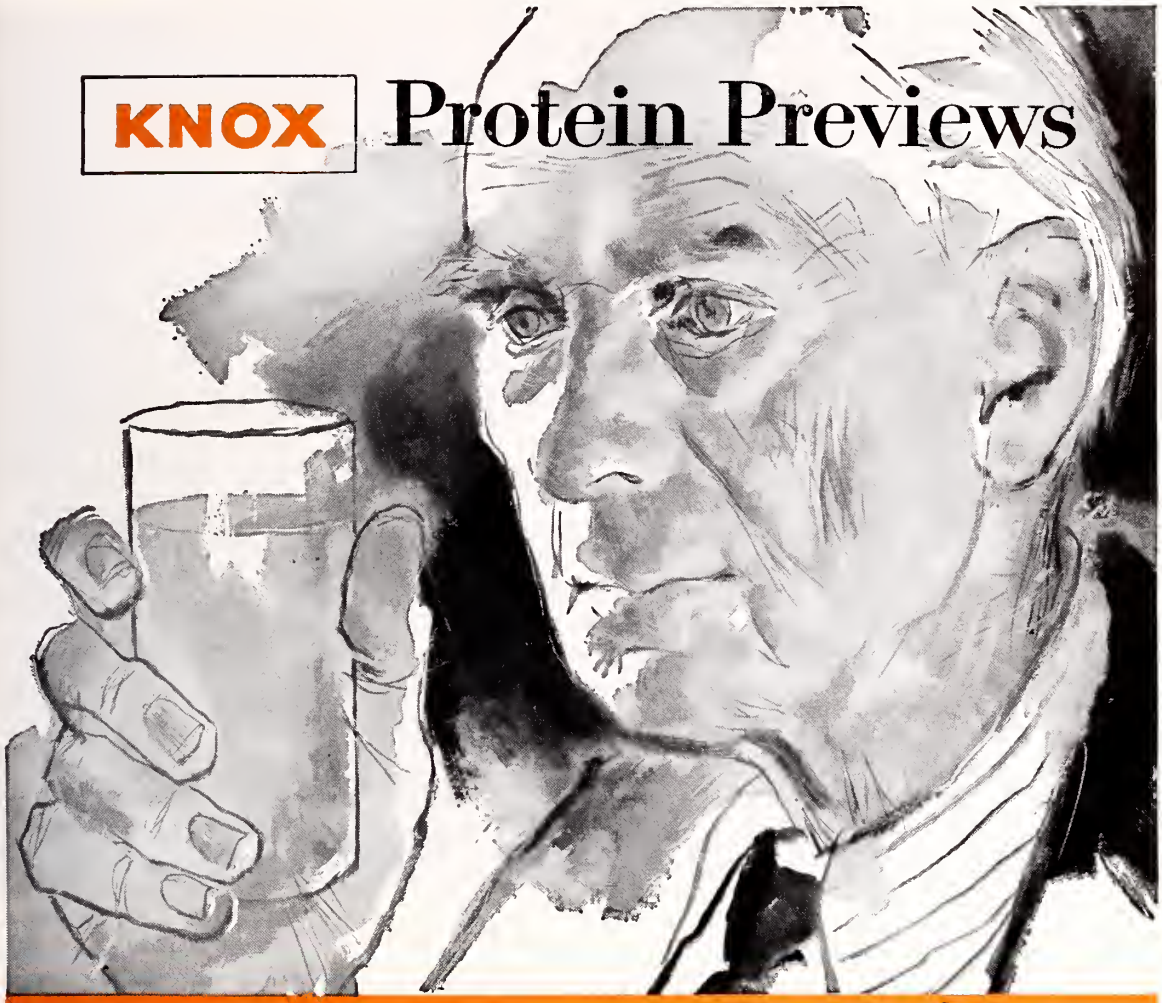
'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.



Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

KNOX Protein Previews



Maintaining Lean Body Mass
in the Edentulous Geriatric Patient



Extensive loss of body protein can occur in either the spare or obese geriatric patient. But whatever the patient's somatotype, a decrease in lean body mass is usually the result of inadequate protein intake due to poor dentition, slowed-down digestion and quite frequently, unappetizing main dishes.

Knox Gelatine is an excellent non-residue protein which is easy to chew and readily digested and assimilated. As a vehicle for many foods, Knox Gelatine brightens bland diets, giving a new interest to jaded appetites. As a concentrated protein drink, Knox Gelatine supplies seven out of eight essential amino acids and a majority of the other amino acids composing protein.

Specific suggestions on how to use Knox Gelatine in different types of geriatric diets are described in the booklets listed in the coupon below.

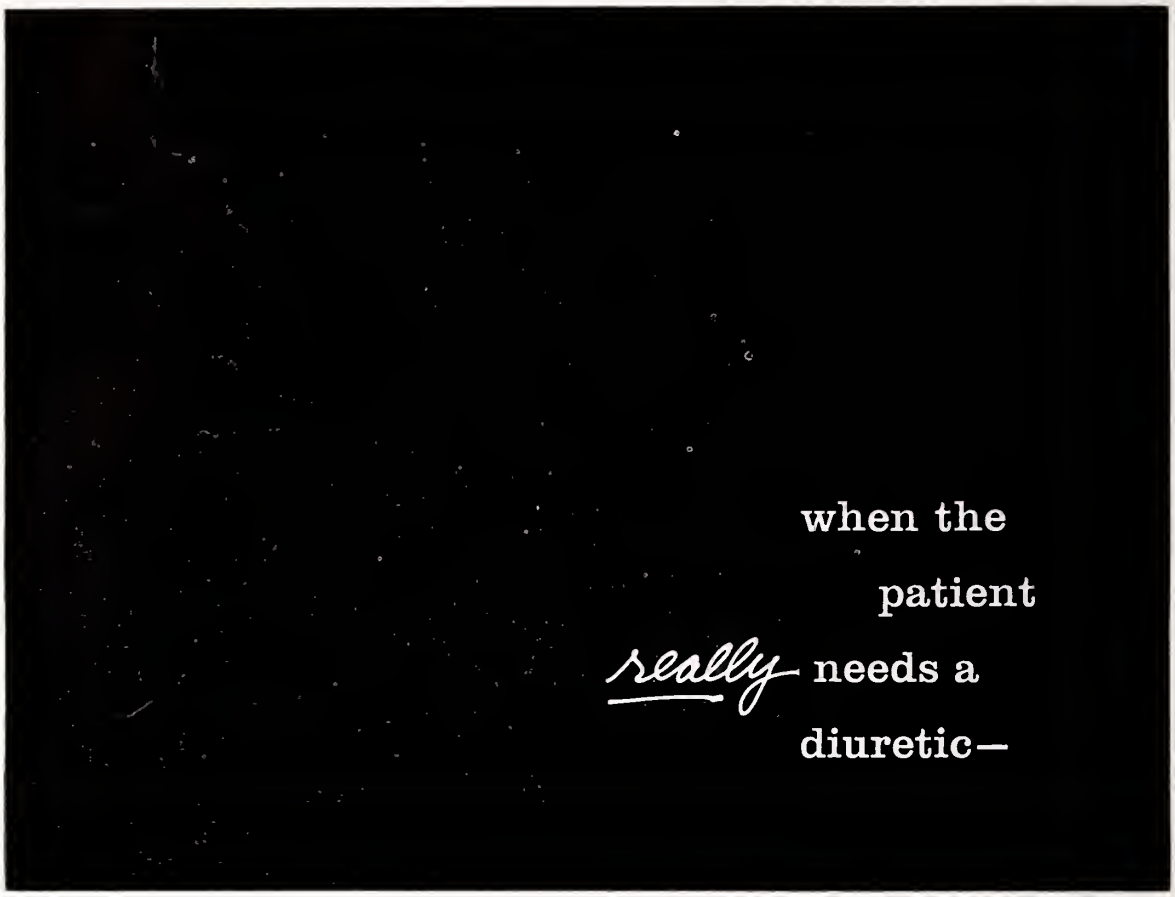
Chas. B. Knox Gelatine Company, Inc.
Professional Service Department SJ-15
Johnstown, N. Y.

Indicate number of special diet booklets desired for your patients opposite title:

GERIATRIC_____ REDUCING_____

DIABETIC_____ CONVALESCENT_____

YOUR NAME AND ADDRESS



HE NEEDS AN ORGANOMERCURIAL

In those patients with borderline or very mild congestive heart failure who can even get along without diuretic therapy, any agent producing minimal or intermittent diuresis may appear to produce benefit.

But when cardiac decompensation—mild, moderate, or severe—is established, dependable and continuously effective diuresis—obtainable only with potent oral organomercurials—is a therapeutic necessity.

TABLET
NEOHYDRIN®
BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure
MERCUHYDRIN® SODIUM
BRAND OF MERALLURIDE INJECTION

LAKESIDE

99456

You can specify

PABLUM®

with confidence!

As a physician, you appreciate the strictness of pharmaceutical standards. Pablum Cereals are the only baby cereals made by nutritional and pharmaceutical *specialists*. That's why you can specify Pablum Cereals with *confidence*.

All four Pablum varieties are especially enriched with iron in its most assimilable form. And all are enriched with thiamine, riboflavin, calcium, phosphorus and copper.

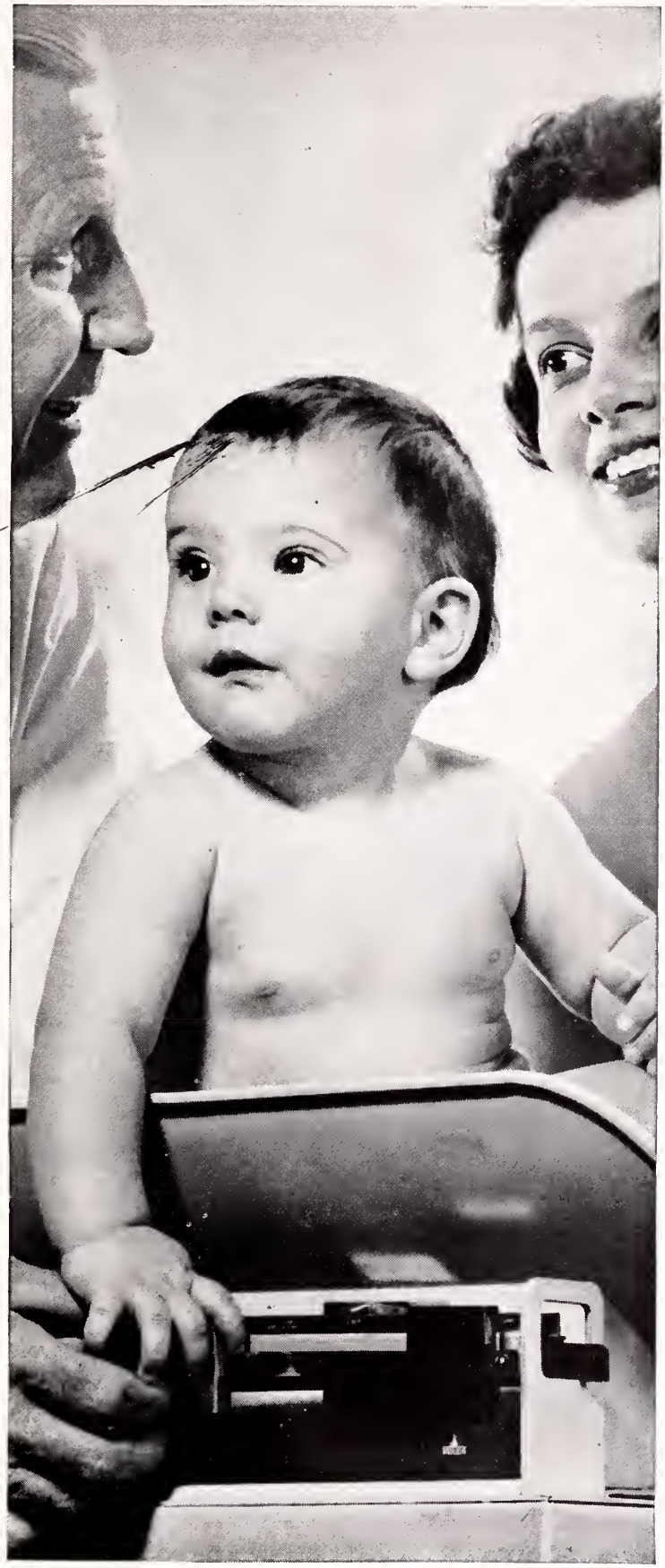
To be sure infants *enjoy* Pablum Cereals, our scientists work tirelessly to make them wonderfully smooth in texture, delightfully delicate in flavor. For your young patients, suggest:

Pablum Mixed Cereal
Pablum Barley Cereal
Pablum Rice Cereal
Pablum Oatmeal

Pablum Products

DIVISION OF MEAD JOHNSON & CO., EVANSVILLE, INDIANA

MANUFACTURERS OF NUTRITIONAL AND PHARMACEUTICAL PRODUCTS.



when patients complain of

unexcelled relief in nonspecif

NEW SIGM

best of the old	Acetylsalicylic acid	325 mg.
potentiated by the best of the new	METICORTEN	0.75 mg.
augmented by	Ascorbic acid	20 mg.
plus	Aluminum hydroxide	75 mg.

METICORTEN (prednisone), new Schering corticosteroid, has three to five times the therapeutic effectiveness, milligram for milligram, of oral cortisone or hydrocortisone. Combined in SIGMAGEN with aspirin and ascorbic acid, it permits unexcelled maintenance of "rheumatic" relief at minimal dosages.

Schering

iff neck • backache • charleyhorse • rheumatics

lumbago • glass arm • devil's grip • bursitis

'ennis elbow • trigger finger • sciatica • neuralgia

heumatic disorders

AGEN
TABLETS

indicated in

muscular rheumatism • mild rheumatoid arthritis • myalgia

mild spondylitis • fibrositis • myositis • subacute gout

pleurodynia • tenosynovitis • panniculitis • frozen-shoulder

packaging

Bottles of 100 and 1000.

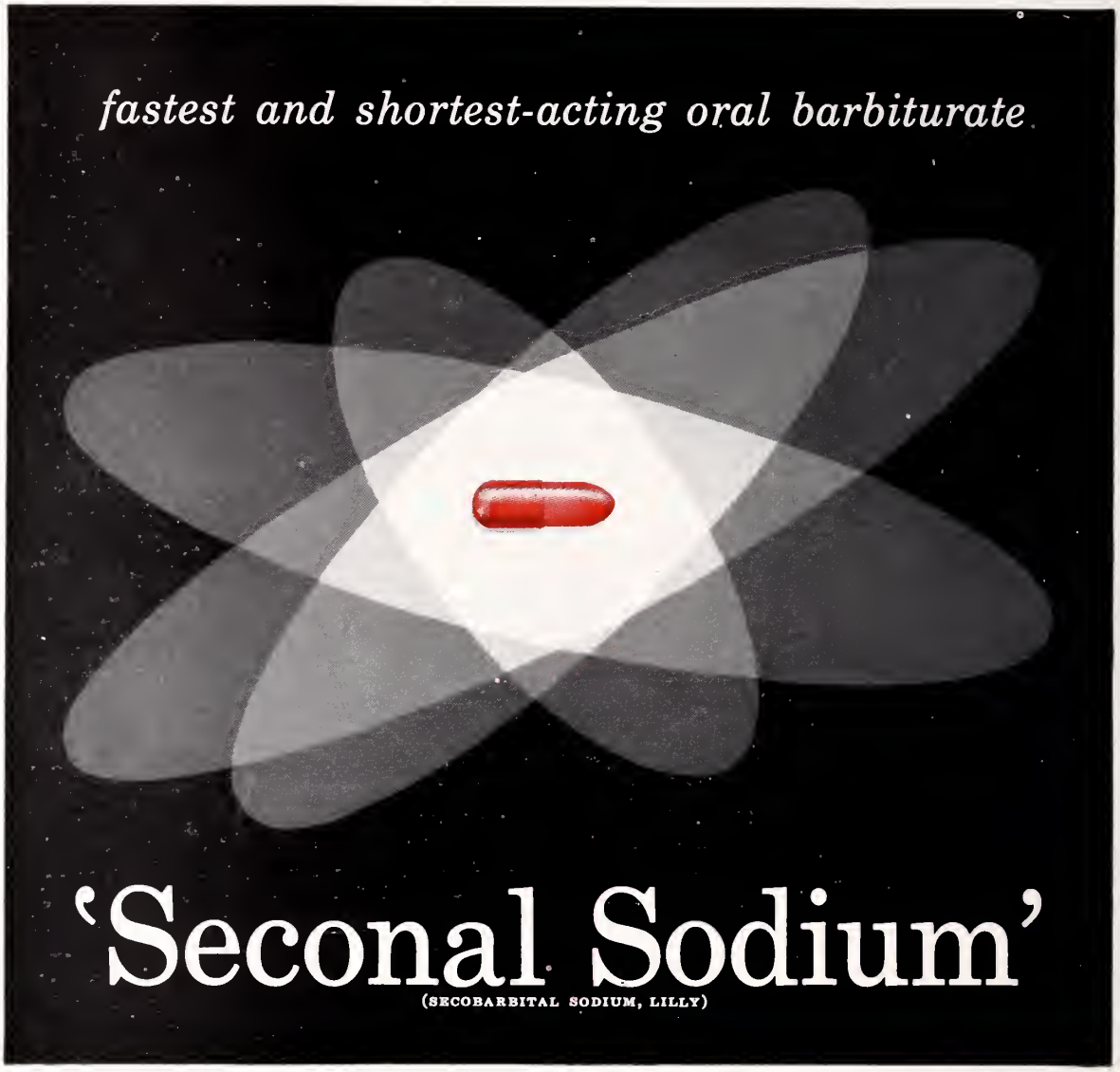
SIGMAGEN,* brand of corticoid-analgesic compound.

METICORTEN,* brand of prednisone.

*T.M.



fastest and shortest-acting oral barbiturate



'Seconal Sodium'

(SECOBARBITAL SODIUM, LILLY)



The secret of sleep in a capsule

When simple insomnia is the presenting complaint, a bedtime dose of 'Seconal Sodium' is often indicated. Its effect is prompt—within fifteen to thirty minutes; relaxation and sleep follow quickly. Your patient awakens refreshed and well rested.

Available in 1/2, 3/4, and 1 1/2-grain pulvules at pharmacies everywhere.

622004

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHTY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 MARCH, 1956 NO. 3

Retropubic Prostatectomy For The Benign Gland*

N. LEWIS BOSWORTH, M.D.
Lexington

The retropubic approach to the benign prostate gland for its removal has been through the trial stage and now takes its place along with the other time honored and accepted methods of prostatectomy. As with any new procedure, there have been many individual variations introduced, but the basic principles of the operation as originally advocated by Terence Millin in August 1945 are still sound and in force today. In many sections of the country this approach has supplanted the suprapubic operation because it meets more fully the basic requirements of good surgery. The ease of execution, the directness of approach and the exceptional visualization of the operative field are its attractive features. In large series the mortality and morbidity rates compare favorably with prostatectomy by any other route.

Approaches

One of the oldest approaches to the prostate gland and one that is widely used to date is the suprapubic or transvesical route: One, two and three stages have been used to do this type of operation although at present it is doubtful that many men use over two stages for this procedure and many men throughout this country and elsewhere are now doing only one stage suprapubic enucleations. The main disadvantage of this operation is that the enucleation is done blindly.

Perineal: This operation has regional popularity depending largely upon the training of the individual in this type of surgery. It is an excellent operation and particularly indicated in the glands showing early malignancy. Its main disadvantages are rectal injury and incontinence. It is also contraindicated in cases in which the preservation of the ejaculatory ducts is a factor.

Transurethral: This operation is probably the most popular approach to the removal of the prostate gland. The distressing features of this operation are delayed hemorrhage, urethral stricture and incomplete removal of large adenomas.

Retropubic: This operation is a very important addition since 1945 and may be performed in one or two stages.

Choice of Operation

The most reasonable formula for choice of type of operation, in my estimation, is as follows: For benign adenomas estimated as approximately 100 grams or over, the retropubic approach is the one of choice. It has been my experience that small glands are difficult through this approach; therefore, for the glands estimated to be under 100 grams and fibrotic bladder necks, transurethral prostatectomy is used. For the early carcinomas of the prostate the radical perineal operation is chosen.

Retropubic Procedures

(1) Simple Prostatectomy: For which the operation was devised. (2) Radical: Removal of the prostate, seminal vesicles and a portion of the bladder in early carcinomas is advocated and practiced by Millin and others, and, undoubtedly, is a sound procedure. However, the perineal route in my experience has given good results and appeals to me as being mechanically less difficult. (3) Bladder neck contractures: Are attacked through the retropubic approach but when the urethra will accommodate the resectoscope there appears to be no real indication for the use of the retropubic route here. (4) The

*Presented before the Kentucky Surgical Society Meeting, May 21, 1955, at Hot Springs, Virginia.

removal of valves and other pathology of the posterior urethra in infants: A very useful and logical addition in the treatment of these conditions where resectoscopic instrumentation is impossible.

Advantages of the Retropubic Operation

The advantages of the retropubic operation are (1) It is performed away from the rectum, and rectal injury should be rare if not absent. (2) Injury to the external sphincter may result from this operation and cases of incontinence do occur, probably from roughness in enucleating the gland and avulsion of the membranous urethra; however, this complication should be eliminated as experience and gentleness are gained. (3) One of the most important advantages of this operation is the complete visualization of bleeding points, capsule and bladder neck. Hemostasis should be accurate, either by ligature or cauterization. (4) Convalescence is short, the patient is ambulatory, as a rule, 24 hours after the operation and the postoperative course is usually benign. (5) There is no planned suprapubic drainage of urine.

Operation

The technical principles of the operation are (1) The incision should be adequate and necessarily larger in fat individuals. (2) Careful attention should be given to the clamping, and either ligating or fulgurating the friable veins in the superficial prostatic fat. This factor alone will minimize the operating time substantially if adhered to. As soon as these veins are broken they retract readily underneath the symphysis and are difficult to recover. It is possible that it is here, where careless fulguration in an attempt to control venous oozing is practiced, that osteitis pubis has its beginning. (3) Control of arterial bleeding from the capsule after the incision is made is very important, and it is here that a large percentage of the blood is lost and not from actual enucleation. In an attempt to get on with the operation an arterial bleeder in the lateral angle of the incision may be allowed to spurt and a considerable amount of blood be lost needlessly. (4) As has been stated before, one of the most important factors in this operation is gentleness in the enucleation of the adenomatous tissue. The presence of an indwelling catheter put in prior to operation and left in through the operation facilitates the removal of the adenomatous tissue and serves as a guide to locate the apex. It also eliminates the possibility of contamination of the operative field. (5) Ligation of the two anterior pedicle attachments at the bladder neck saves time. Some type of hemostasis of the bladder neck at 5 and 7 o'clock, either suture or fulguration, should be routinely used and will obviate a large percentage of early postoperative hemorrhage since it is largely the bladder neck bleeders that are responsible in this complication and not the capsular oozers. (6) The removal of a "V" shaped wedge from the posterior lip of the sclerotic bladder neck is important. (7) A water tight closure of the capsule either by interrupted mattress sutures or over and over continuous sutures or by any other means should be accomplished. This not only prevents leakage of urine but also controls bleeding from the edge of the capsule that may have been overlooked.

Complications

(1) Hemorrhage: If and when bleeding occurs to the extent that it is not controlled by catheter irrigation, then it has become the practice of most urologists to fulgurate the bleeders through the resectoscope. (2) Fortunately wound infection is not too common an occurrence if adequate drainage is maintained over a long enough period. As a rule there is no set time for removal of drains, but when drainage stops the drains are taken out. This usually is within a 48-72 hour period. (3) Postoperative retention is an occasional complication and may be due to a very small nodule remaining in a strategic position. (4) Incontinence of urine following this type of procedure occurs in a small percentage of cases just as it does in any other type of prostatic operation but usually clears up within a matter of days to a few weeks' time. (5) Osteitis pubis is probably one of the most distressing complications but is a self-limited one. There is no specific treatment, and its cause is not definitely known. (6) Mortality: In the reported large series of cases throughout this country and abroad, the mortality ranges between 1.6% and 5%. In most instances in this country the figure is a very acceptable one and averages about 2%. Most of the deaths occurring following this operation can be classified as cardiovascular accidents, and only an occasional death is a direct result of the operative procedure.

Summary

Retropubic prostatectomy is discussed from the standpoint of approaches, indications, procedures, advantages and technical principles.

Clinical Partiiions In Pediatrics*

FREDERIC N. SILVERMAN, M.D.**

Cincinnati, Ohio

The opportunity to present this discussion places me in an unusual, but not unpleasant situation. Generally, I have been privileged to address similar meetings on fairly sharply limited subjects in the guise of an "authority." An "authority," you know, has been defined as "a fellow from another city with a lot of slides." Previously, I have dealt with ideas and facts which could be reduced to slides, particularly of x-ray films. One of my radiologic friends from this city, coined the term "radioactive pediatrician" to designate a kind of super-specialist who would occupy himself as I may appear to do.

It is from this position of a so called "super-specialist" that I am going to present the thesis that partitions of pediatrics into super-specialties are disadvantageous —and that they lead to a tendency for pediatricians to shift responsibility for thinking along certain lines, to other physicians whose overall qualifications for child care actually are not so good as those of the referring physician. And I am going to develop this idea without so much as a single slide—let alone an x-ray film.

Specialty Boards

Although specialization did not begin with, it received its greatest impetus from, the formation of formal Boards of Specialties. The American Board of Ophthalmology was founded in 1918, the first of a series of similar bodies in other specialized fields of medicine. The American Board of Pediatrics came into existence in 1931. Like its predecessors, its purpose has been to set the standards to be met by those who wish to be recognized as having special proficiency in a given field; in this instance, the care of children. Emerson North, M.D., who was professor of pyschiatry at the University of Cincinnati from 1933 to 1942, once told me that this movement toward specialization was probably the strongest single factor favoring the development of pyschiatry. As the general practitioner, the family doctor, began to disappear from the American scene, the specialty of psychiatry had to be developed to replace the understanding, impartial confidant who was no longer available.

The boards of specialties do not determine the nature of medical practice; it is the practice of medicine which determines the foundation of boards. It is therefore disturbing to note the trend toward further special divisions as pediatric allergy, pediatric surgery, pediatric pyschiatry, and even pediatric roentgenology. When these divisions are restrictive, as implied for instance in the term "pediatric roentgenology" as opposed to "roentgenology in pediatrics," they impose arbitrary clinical partitions on pediatrics which tend to deny the child and his family the services of the general pediatrician, one of the few "GP's" remaining. Other specialty groups which make no claim to the modifying word "pediatric" can contribute to this medical fence-building. We all know that the true general pediatrician does not treat just the child, but the child in relation to his family and his entire environment insofar as he can. This common sense attitude has been glorified as the "concept of the whole child," which is a good concept. The care of the "whole child" is the goal of pediatrics in its supervisory role as well as its therapeutic role; but unless we have a "whole pediatrician" to accomplish this end, our care is incomplete. As indicative of the partitions of which I speak, it may be pointed out that there is only one pediatric text book which still reflects the work of one author, and that is the one by James Hughes, M.D., who is with us at this meeting. All the other text books used for instruction of students and for reference by clinicians are the product of a group of superspecialists. The division of labor may be advisable for writing a text book, but I maintain it is not so for the practice of pediatrics.

Adverse Effects of Partitioning

Perhaps some of the ways in which clinical partitions in pediatrics act adversely are best illustrated by recounting a few experiences which have been collected since the title for this talk was agreed upon. These are instances in which symptoms related to a specific organ system led to premature unnecessary refer-

*Presented to the Kentucky Chapter, American Academy of Pediatrics at the Annual Meeting of The Kentucky State Medical Association, in Louisville, September 29, 1955.

**Director, Department of Roentgenology, Children's Hospital, Cincinnati.

ral to a "specialist;" or in which concern over a narrow aspect of disease, expressing the limitations of the specialist, led to inadequate care of the entire situation. In some instances, failure of the family physician to assume adequate responsibility for care of the child led to these unnecessary referrals.

Let us consider the case of a 17 month old white female who was sent to the hospital by a staff orthopedic surgeon for biopsy of a lesion of the left clavicle. About two weeks earlier she had fallen in her crib; several days later, when the mother accidentally touched the region of the left clavicle, the child withdrew as if it were tender. The next day, remembering the incident, the mother noted a swelling in this region; and a few days before admission she called her pediatrician who without examining the child, referred her to the orthopedist. Since the complaint was related to the collar bone, naturally a bone specialist was needed. An x-ray was taken of the area and demonstrated a lesion and the child was admitted to the hospital with the diagnosis of tumor. The physical examination on admission showed a somewhat tender swelling in the medial third of the left clavicular region which was hard, smooth, and apparently represented an enlargement of the bone. The skin was not red over the area, nor warm. X-ray examination of the area in question revealed a destructive lesion which had characteristics suggesting eosinophilic granuloma. Because we have learned that it is always wise to consider the possibility that a given lesion represents a local manifestation of systemic disease, a complete skeletal survey was requested by the x-ray department. This revealed a similar lesion in the neck of the left femur which had been totally unsuspected, but no other abnormalities. The new finding gave a different complexion to the original diagnosis; this was systemic disease!

Whenever more than one lesion of eosinophilic granuloma is found, particularly in a young child, the average well trained pediatrician finds his thoughts running in the direction of the first manifestations of Hand - Schuller - Christian and/or Letterer-Siwe's disease. However, the report of the biopsy as eosinophilic granuloma satisfied the orthopedic surgeon. The child was discharged as soon as wound healing was complete and received a course of x-ray therapy to both lesions.

The child was next seen in the hospital six months later, this time as a patient of an ear-nose and throat specialist to whom she had been referred four months earlier because of a running ear. This competent specialist, with knowledge of the previous diagnosis of eosinophilic granuloma, but unable to relate it to the present complaint—after all, what do bone lesions have to do with a running ear?—had been treating the ear for four months. Three months prior to the second admission, x-rays of the mastoids were taken in another department and another area of destruction was described. At the time of the second admission, the area of destruction in the temporal bone was reexamined and found to have increased. There was also a punched out area in the parietal bone. On review of films taken in the other hospital, the lesion in the parietal bone could be identified, although it was somewhat smaller. So much attention had been focused on the ear-mastoid region because this child was a patient of an ear-nose-and throat specialist, that the lesion at the margin of the film was missed. At the time of this second admission, the child also demonstrated skin lesions over the neck and chest which resembled scabies, but which, of course, means only one thing to all of us here, that the cutaneous manifestations of Letterer-Siwe's disease were making their appearance in what practically amounts to a classical case of the condition. This child's diagnosis was delayed at least four months because the limitations of "specialists" were focused on a bone, or an ear, and not on a child. To any well trained or well read pediatrician, a combination of a "proved eosinophilic granuloma" in one area, an asymptomatic lesion of similar type in another area, a chronic draining ear with destruction in the mastoid bone, a punched out area in the skull, and scabetic-like lesions in the skin would mean Letterer-Siwe's disease until it could be proved otherwise. To the specialists however, the diagnosis was eosinophilic granuloma—an orthopedic disease treated by excision and x-ray; and chronic otitis, a problem for the oto-rhino-laryngologist. Had there been proper whole child-whole pediatrician care, the diagnosis most certainly would have been made at the time when the new symptom of draining ear was added to the radiologic signs of bone lesion. This may be a bad case to illustrate the point, because the prognosis of the condition is not necessarily altered by early diagnosis. This child subsequently

developed mandibular lesions, lost many teeth, and even developed diabetes insipidis. She has had a fairly good response to, or at least a remission after, the administration of ACTH and x-ray therapy, and is at present enjoying relatively normal activity.

Another Example

Perhaps a better example is provided by the next case: A 12 year old boy was admitted to the hospital four months after a fracture of the left femur while playing. The youngster had been vigorous and active up to the time of injury. As is customary, following reduction of the fracture, a cast was applied including the entire lower extremity and the lower half, at least, of the trunk.

A few days later, the boy began to vomit and complained of severe headaches. These symptoms continued unexplained and un-investigated by the "fracture-specialist" for two months, at which time generalized convulsions supervened. The cast was removed after two days, and the convulsions ceased, but because healing was incomplete by x-ray, it was re-applied. Vomiting recurred, and ten days later, convulsions began again. After five days, he was sent to another hospital for neurological consultation because of hypertension and papilledema. Ventriculograms were done, but were normal. To aid in fracture healing he was given large quantities of milk and sodium bicarbonate. He was then found to have hypercalcemia. The surgical consultant recommended a neck exploration which was undertaken, but the parathyroid glands could not be identified. Convulsions, hypertension, and hypercalcemia continued. Renal dysfunction became evident with an increase in the non-protein nitrogen content of the blood, a decrease in the phenolsulfonphthalein clearance, and low specific gravity. It was in this state that the child was transferred to Children's Hospital.

On admission, the child was poorly nourished and irritable. The left leg and the lower trunk were encased in a hip spica. The optic disks were blurred and there was evidence of old and new retinal hemorrhages bilaterally. The blood pressure ranged between 160-180/120-130. This patient, who baffled the orthopedic surgeon who originally treated the fracture, the neuro-surgeon who felt it necessary to do ventriculograms, and the general surgeon who unsuccessfully sought a parathyroid tumor, presented a clear cut syndrome to the pediatrician who took care of him for the first time. It is probably pertinent to note that the pediatrician happened to be Katie Dodd, M.D.,*—yet, Doctor Dodd is a good example of what I mean by the phrase "the whole pediatrician." Because of her ability to integrate the information available in the history and examination of this child, and because she accepted completely the responsibility for supervising the total care of this child, she was able to make a diagnosis and initiate the proper course of therapy. Doctor Dodd recognized that the problem was one of immobilization and the associated biochemical changes—what is called "the cast syndrome."

When a previously active individual is totally immobilized, as is done very effectively by a hip spica, certain changes take place in the body. Among them is a prompt significant mobilization of calcium from the now inactive bones; the resulting hypercalcemia may produce renal damage, hypertension, and encephalopathy as in this boy; and recovery is related to permanence of the damage and the reversability following discontinuance of the extreme body immobilization.

A happy result was obtained in the youngster in question with improvement beginning within 2-3 days after Doctor Dodd persuaded the orthopedic service to remove the cast.

This is an instance in which a pediatrician allowed her mind to consider the causes of convulsions rather than immediately turning the patient over to a "convulsion" specialist. The pediatrician accepted her basic responsibility, maintained control of the patient, and the patient benefited. Properly used consultants make their contribution through the referring physician; to relinquish patient responsibility is to abuse rather than use specialist consultation.

Additional Illustrations

I should like to recount one other experience, in which too restricted an interpretation of x-ray films by this speaker contributed to erroneous diagnosis. A 10½ year-old boy was admitted to the hospital last March with a complaint of persistent and recurrent back pain. Four months earlier, after participating in gym in what is called "crab-racing," he first complained of severe back pain. The back was stiff and pain radiated down in the right thigh

*This case has been reported in detail by Dodd, Graubarth, and Rapport, Pediatrics 6: 125-130, 1950.

and leg. A physician taped the back and gave diathermy treatment and the pain subsided; in one to two days it recurred more severely than before and persisted for three weeks. After another free period of about ten days, recurrence again took place. Once again the back was taped, aspirin was prescribed, and oral penicillin was administered. Pain is spasms recurred three to four times daily; after two months of this the patient was referred to an orthopedist, who obtained a series of x-rays which were reported to show no pathologic change. A back brace was applied, but this appeared to make the pain worse. At the time of admission, four months after the onset, the patient had lost eight pounds in weight and his back was so stiff he could not bend to tie his shoe. X-ray examination of the spine at this time showed narrowing of the interspaces between D 10 and 11, irregular destruction of the adjacent surfaces of the body and a paravertebral soft tissue mass interpreted as an abscess.

These findings were interpreted as "characteristic of tuberculosis" and treatment with the standard triad of antituberculous drugs was begun. Two days after the x-ray examination, the intradermal tuberculin test was found to be negative. As pediatricians, we have come to place great faith in the intradermal tuberculin test in the diagnosis of tuberculosis, and the finding of a negative tuberculin test is an indication for serious reconsideration of the diagnosis. The child had not had measles or other viral diseases recently to depress his tuberculin sensitivity; neither was he sufficiently debilitated to be unable to react. Revaluation of the roentgen films in the light of this negative tuberculin test showed that we had been too glib in calling the lesion "characteristic" of tuberculosis. There was too much sclerosis and bone reaction in the vertebral bodies adjacent to the areas of destruction. Moreover, in using the word "characteristic" we had been violating a principle of interpretation which we ourselves had voiced repeatedly to our staff, namely, that the x-rays deal only with shadows and that many different conditions may have a similar radiographic appearance. It was not difficult then to bring into the differential diagnosis the possibility of a low grade osteomyelitis of the spine and to find similar cases in the literature or in the unreported experience of other physicians with whom we talked. Aspiration of the paravertebral soft tissue shadow was thought perhaps to carry the clue to the correct diagnosis. The orthopedist was reluctant to accept any diagnosis other than tuberculosis and insisted on the continuance of therapy which in these days is tantamount to a sentence of at least six months duration. It took us a full week to persuade him to let us carefully introduce a needle into the paraspinal soft tissue swelling. When this was done, although a definite abscess was not encountered, the small amount of bloody fluid which was withdrawn was found to contain hemolytic staphylococcus aureus, coagulase positive and sensitive to penicillin. It was another week before we were able to institute adequate penicillin therapy and a few days later following a surprising relief of clinical symptoms, the streptomycin, para-aminosalicylic acid, and isoniazide were discontinued. The subsequent course of this boy has been very gratifying. The soft tissue paravertebral abscess became progressively smaller and the area of bone destruction began to fill in to the point that autofusion was seen to be taking place with little or no deformity. A pleural effusion developed about three weeks after the aspiration of the abscess; the fluid was sterile and we were not able to say whether it was a sequel to the aspiration or a spontaneous extension from the abscess. The subsequent clinical course was entirely without incident and when last seen, there was progressive radiologic healing of the lesion in the vertebral bodies and progressive fusion.

In this case an initial over-enthusiastic interpretation of x-ray films led to the strong statement that the shadows were "diagnostic of tuberculosis." At the same time, a report of the electrophoretic pattern of the serum proteins was said to show high protein value with increased globulin—"characteristic for tuberculosis."

This is a beautiful example of just how wrong the super-specialist can be because of his preoccupation with just one facet of the entire picture. The radiologist looking only at a film; and the chemist only at values for protein in the blood. There are many other instances which could have been used—probably more interesting and more pointed than the three cases I have recounted. For example, we might cite the case of the pediatric allergist unsuccessfully treating a child referred to him with asthma until the foreign body was removed from the bronchial tree; or the pediatric pyschiatrist carefully altering the environment of the room of a depressed negativistic child, and the attitude of

the nurses and interns about her, shortly before she dies of her unsuspected brain tumor.

On Assuming Responsibility

A medical center offers great opportunities for shifting responsibility to "specialists;" I have seen an otherwise competent resident hear a heart murmur and immediately refer the patient to the staff cardiologist instead of attempting to evaluate this one finding himself. The subspecialists who are needed in these medical centers, where facilities exist for the exploration of narrow frontiers, provide "answers" so readily that the stimulus to find out for himself may suffer a disuse atrophy in the pediatric resident. In this respect, our training centers must bear the brunt of the criticism for not turning out "general pediatricians;" but the practitioner himself is not blameless. It is much easier to refer a patient to a "consultant" when response to "wide-spectrum" medication (I do not call it treatment) in an incompletely examined patient, is not sufficiently rapid to command the admiration of the family, than it is to review the history in greater detail and do the complete physical examination the situation demands. The simple routine of a pertinent history and physical examination is adequate to permit a diagnosis in a majority of cases of disease in childhood; the specialist consultant is necessary to evaluate the relatively small group of patients whose problems require additional tests or examinations not in the province of the general practitioner. But, notwithstanding the popular definition, one does not have to be a super-specialist to do a rectal examination to aid, for example, in a differentiation between Hirschsprung's disease and symptomatic megacolon; or to take a blood pressure to recognize the wide pulse pressure of patency of the ductus arteriosus in a child with a heart murmur; or to palpate for femoral arteries to help evaluate the cause of cardiac failure in a young infant; or to do an initial examination of the eye grounds in a child with symptoms referable to the central nervous system. The easy way of referring patients to consultants before an adequate personal evaluation relegates the pediatrician to the position of a traffic manager for his consultants; he repudiates his responsibility to his patients and deprives himself of some of the most gratifying experiences of medical practice. The "whole-pediatrician" therefore will know his limitations and use his consultants wisely; but he will also recognize his own abilities and the advantages of his position as a general pediatrician and exploit them for the benefit of the "whole-child." We can be grateful for the availability of super-specialists for those times when they are really needed. Let them plow their narrow furrows, deep as they wish; the practicing pediatrician should be prepared to cover the whole field and reap the crop of worthwhile future citizens.

In closing, I might say that this discussion may be considered as an introduction to a "do-it-yourself" course for pediatricians. The remainder of this course should be found in your training, your books, and your journals; and in your pride, and in your ability and responsibility, tempered by your good judgement.

Manuscript Memos

Manuscripts should be submitted in duplicate to the Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Mr. J. G. Denhardt, Times-Journal Publishing Company, Bowling Green, Kentucky.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.

An Oblique Upper Abdominal Incision*

HENRY S. COLLIER, M. D.

Louisville

An abdominal incision should meet the following basic requirements:

(1) It should give the most direct approach to the pathology to be treated.

(2) It should be placed so that if extension is necessary this may be done with ease.

(3) Vital structures should not be damaged.

(4) Closure of the incision should not be under such tension as to result in disruption and postoperative hernia.

(5) The length should be adequate to give proper exposure.

(6) Postoperative pain and muscular splinting should be at a minimum, giving the least number of chest complications.

(7) Retraction to obtain adequate exposure should not have to be so hard as to traumatize the abdominal wall.

Basic Types

There are three basic types of upper abdominal incisions.

(1) Vertical incisions, which may be midline, transrectus, or paramedian.

(2) Transverse incisions, dividing one or both recti muscles, and dividing the other fascia in the line of the skin incision.

(3) Subcostal incisions, both left and right side.

Combinations of these basic types may convert an incision into an "L," inverted "Y", "T", or various other shapes and letters. All incisions have certain advantages and disadvantages, and no one type of incision will always be the most advantageous.

What are the most commonly used incisions in upper abdominal work today? J. Summers, in his article in the American Journal of Surgery, August 1952, entitled "Incision: Present Status in the United States," presented statistical studies from questionnaires sent to a thousand diplomates of the American Board of Surgery in 1950. In doing cholecystectomy for chronic disease or stones, the Kocher incision was used most frequently—38.8% of surgeons preferring it. The second most commonly used was a vertical incision—34% using this. 18% used a transverse incision. 13.2% used either a vertical incision for narrow subcostal angle, or transverse or subcostal incision when the costal cage was wide. In doing gastrectomy, the upper left paramedian incision was used most frequently—23.3%. 16.4% used an upper midline. 14.1% used a straight transverse incision. The remaining surgeons used curved transverse, left subcostal, inverted "V", and right subcostal incisions.

Today I am presenting an upper abdominal incision which basically is the abdominal portion of the thoraco-abdominal incision. This incision has been used by my associate, R. Arnold Griswold, and myself over a period of the past five years. We have found its greatest use in biliary surgery. No originality is claimed for this incision. In reviewing the literature, it was found that it was first described by C. Gale in the Australian and New Zealand Journal of Surgery, Volume 19, August 1949 in an article entitled "Approach to the Upper Abdomen." He described the incision and advocated its use for the surgery of the gallbladder and common duct. A somewhat similar description with slight variations, was made by J. S. Carman in the Journal of International College of Surgeons, Volume 13, March 1950, in an article entitled "Incisions for Exposure of the Gallbladder." At that time he stated that he was unable to find a description of a similar incision in the literature. It would be difficult to attach anyone's name to the incision, because it is essentially the abdominal portion of a thoraco-abdominal incision. I believe it should be named simply an oblique upper abdominal incision.

Description of Incision

This incision extends over the lower costal cage, either on the right or left side, beginning about the 7th interspace, approximately 2-2½ inches above the lower costal margin, and extending in the same general direction as the interspace across the upper abdomen, crossing the midline at about 1½ - 2 inches above the umbilicus, and generally extending an inch to 2 inches beyond the midline. The muscles and fascia are divided in line with the skin incision. The external oblique muscle is incised over the lower

*Presented before the Kentucky Surgical Society Meeting, May 21, 1955, at Hot Springs, Virginia.

costal cage. The rectus muscle may be divided transversely or obliquely in the line of incision. The internal oblique and transversus muscles are incised behind the costal cage, and the transversalis fascia and peritoneum are opened posterior to the costal cage for a distance of approximately 2 inches. When a self-retaining retractor is placed, it will be observed that the opening becomes kite or diamond shaped, with the widest portion of the opening at the point immediately below the costal margin. This generally will give the greatest exposure at the level of the infra-hepatic region, and so therefore will expose the gallbladder and common duct area. The incision will make an angle of approximately 30° with the transverse line at the waist. It can be enlarged superiorly by going across costal cartilages and extending into the 7th interspace and into the chest if necessary, dividing the diaphragm if one so desires. It may also be enlarged in several directions by extending the lateral extremity, or by extensions either vertically or transversely. When more room is desired it is advisable to devide both recti muscles.

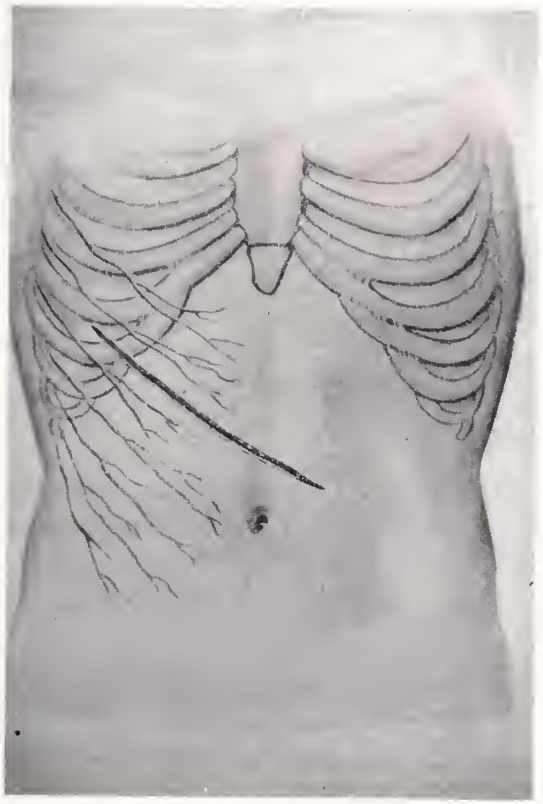


Figure 1

Drawing showing the position of the marked out incision for cholecystectomy. Costal cage and intercostal nerves are drawn in to show relationship of the incision to these structures.

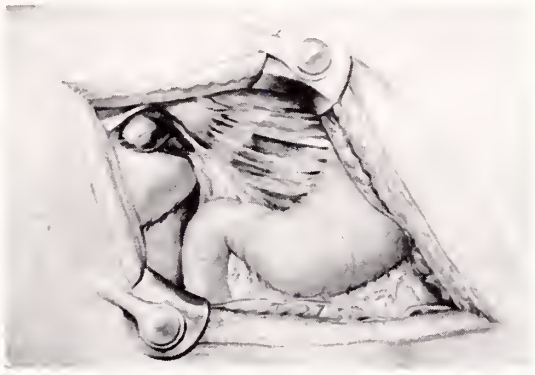


Figure 2

Drawing showing exposure after placing self-retained retractor. The kite-shaped opening is shown with the widest exposure at the infra-hepatic region. It will be noted that the free edge of the duodeno-hepatic ligament, in which the common duct is located, runs parallel to the line of the incisional opening.

We have found this incision best adaptable for cholecystectomy and exploration of the common bile duct. However, the incision placed on the right has been used also for pyloroplasties, procedures on the first and second portions of the duodenum, and for resections of the right half of the transverse: Using the oblique incision on the left side, we have found it satisfactory for sub-diaphragmatic vagotomy, gastroenterostomy, gastric resection, splenectomy, colon resection involving the left half of the transverse colon and splenic flexure, and for surgery of the pancreas. The advantages are:

(1) It is placed in line with the nerves and blood supply to the upper abdomen.

(2) The widest exposure is at the point desired—that is, in biliary surgery, immediately below the costal cage.

(3) It is placed immediately over the parts to be exposed, and generally no deep or vigorous retraction is needed.

(4) The exposure is not limited by the flare of the costal margin as is the high transverse incision.

(5) There is great ease of extension for surgery to include other upper abdominal viscera, or even to include surgery to be done in the pelvis.

(6) Closure is firm and anatomical.

(7) Sutures are placed in the fascia at right angles to the direction of the fibers of the fascia.

(8) The patient is generally more comfortable postoperatively, and after a period of forty-eight hours is almost free of pain, with the exception that there is usually some discomfort immediately over the costal-margin—this seems to be the only disadvantage to the incision. Apparently, as the healing process proceeds there occurs an adherence between the muscles and fascia anterior to the costal cage and those running posterior to the costal cage, preventing the normal gliding action of these muscles over and under the lower edge of the costal margin. We have found that this discomfort disappears completely within four to six weeks postoperatively.

(9) When the incision is placed on the left side for gastric surgery it will give an adequate exposure of the two most fixed points of the stomach—that is at the esophagocardial junction and at the pylorus. The incision also will run in the general direction of the body of the stomach.

(10) On the right side it has been noticed that after retracting the stomach, duodenum, and abdominal contents inferiorly, and having placed retractors on the inferior surface of the liver the common duct is in a position which is almost parallel to the line of incision. In this position the operator is looking directly down upon the structures upon which he is working, and not trying to see around a corner.

Summary

An oblique upper abdominal incision has been described. It has been found to be useful in doing surgery of any structures in the upper abdomen, placing the incision either to the right or to the left. There are anatomical advantages in the placement of this incision, and the exposure obtained is adequate and easy. This incision has been found to be particularly useful in doing biliary surgery, but also has usefulness in surgery of the stomach and duodenum, the transverse, hepatic, and splenic flexures of the colon, the spleen, and pancreas. The advantages and disadvantages of the incision are described.

BIBLIOGRAPHY

Carman, J. S., "Incision for Exposure of the Gallbladder," Internat. Coll. of Surg. 13: 300-305, March 1950.

Gale, C., "Approach to Upper Abdomen," Australian & New Zealand J. Surg. 19: 85-89, Aug. 1949.

Rogers, J. C. T., "Diagonal Incision for the Upper Abdomen," Surg., Gyn., and Obst. 92: 698-699 June 1951.

Lee, A. E., "Making of Incisions," Med. J. Australia 1: 575-577 Apr. 30, 1949.

Lahey, Frank, P.P. 773, "Surgical Exposures," Surgical Clinics of North America, June, 1950.

Summers, J. E., "Incisions: Present Status in U. S.," American Jour. of Surg., 84: 177-181, Aug. 1952.

The Use of Cortisone in Aged Patients with Acute Infections

WILLIAM A. BLODGETT, M.D.
JAMES ROBERT HENDON, M.D.
LAWRENCE T. MINISH, JR., M.D.
Louisville

It is the purpose of this report to emphasize a sphere of clinical usefulness of adrenocortical steroid therapy which has received little attention to date—the treatment of overwhelming infection in the aged patient.

Masking Potentiality

From the first introduction of ACTH and cortisone into clinical medicine, the dangers of their use in bacterial infections have been emphasized. Numerous cases of fatal intercurrent and unsuspected infections occurring during the course of steroid treatment of rheumatoid arthritis, disseminated lupus erythematosis, and other diseases have been reported. Finland and co-workers demonstrated the dramatic clinical response in patients with lobar pneumococcal pneumonia treated with ACTH alone. They noted, however, the persistence of positive blood and sputum cultures, the continued pulmonary consolidation, and the absence of phagocytosis of pneumococci in the sputum. The perforation of peptic ulcer leading to overwhelming peritonitis in the presence of minimal clinical signs emphasized the masking potentiality of steroid therapy and the apparent lowering of resistance to infection. Reactivation of supposedly quiescent tuberculous infection and spread of minimal tuberculous lesions during cortisone and ACTH therapy has indicated the

need for care in the use of these hormones when dealing with infection.

The paradox of clinical improvement while the underlying disease state continues at an unabated or even accelerated rate has been the basis for the concern which has attended widespread use of these agents in a variety of disease states.

Host Response Alteration

This paradox has led to considerable speculation concerning the role of ACTH and cortisone in infectious diseases and the immune mechanism. Lack of antibacterial activity of these hormones has indicated clearly that it is the response of the host which is altered rather than the bacterial organism. Antibody response is interfered with little, if at all, indicating that there is no specific suppression of the immune mechanism. Some phases of the hypersensitivity mechanisms are altered by ACTH and cortisone, but not with sufficient specificity to separate the alteration from an effect on the inflammatory process in general. While the mechanism remains obscure, it is clear that the common denominator of the wide variety of states affected by ACTH and cortisone is inflammation.

Evidence of adrenal cortical activation as part of the physiologic response to infection has been obtained in studies on patients at the height of acute illness. It is attractive to speculate that adrenal cortical failure plays a role in the fatal termination of overwhelming infections, such as the Waterhouse-Friderichsen syndrome, diphtheria, and overwhelming toxemia in the aged.

With the realization that the action of ACTH and cortisone in infectious diseases is probably identical with their action in inflammation produced by a variety of chemical and physical agents, it has been logical to combine their use with that of antibacterial agents in combating certain infections. Woodward, Smadel, and others have shown that the combined use of cortisone and chloramphenicol in the treatment of typhoid fever decreased the morbidity of that disease by several days and lowered the incidence of expected relapses materially. Similarly, in Rocky Mountain Spotted Fever, tetanus, and meningococcemia, favorable responses have been obtained in terms of rapid reduction in toxicity while the antibiotics produced the desired antibacterial response.

The following case summaries indicate a particular group of patients in which this principle was applied with gratifying results.

Case I

A 76 year old female was admitted to the hospital on March 2, 1952,with a four-day history of fever and progressive weakness. For two days prior to admission, she had been comatose, with fixed gaze, unable to respond and had been diagnosed as having had a cerebro-vascular accident. The findings of marked nuchal rigidity and a temperature of 103.8 suggested the diagnosis of meningitis, and this was confirmed by lumbar puncture, which showed a cloudy spinal fluid with an initial cell count of 23,000 leucocytes per cu. mm. Her condition was obviously poor with a rapid, irregular pulse, cyanosis, basal rales in the lungs, and skeletal muscular twitching.

Gram stain of the spinal fluid revealed an encapsulated diplococcus; but differentiation between pneumococcus, influenza, and Friedlander's bacillus was impossible on morphological grounds. Multiple antibiotic therapy was begun with penicillin-streptomycin combination intramuscularly and aureomycin-sulfadiazene therapy intravenously. Additional supportive measures included oxygen by tent, digitalization, and intravenous fluids.

The first 24-hour period was marked by generalized convulsions and deepening coma with stertorous respiration and accumulating tracheal secretions. It seemed impossible that she could survive this moribund state, and cortisone was begun with little expectation of improvement. The initial dosage was 100 mgm. intramuscularly at six-hour intervals.

At the end of the next 24-hour period, no appreciable improvement could be detected except some decline in fever which could not be interpreted as improvement since the blood pressure had fallen to shock levels, the pulse volume was perceptibly smaller, urinary output decreased markedly, and a hemolytic process was evidenced by a falling red cell count and bilirubinuria. Treatment was continued as before, however; and in the next 24-hour period, during which time 300 mgm. of cortisone was given, a dramatic change occurred. The blood pressure returned to normal levels, cardiac output improved, urine volume increased, a blink reflex was noted, and a spinal fluid examination showed a marked drop in cell count to 382 cells per cu. mm.

A day later she was conscious, reason-

ably coherent, and taking fluids by mouth. Combined cortisone and antibiotic therapy was continued for 10 days, and cortisone was then discontinued in a stepwise fashion. The antibacterial agents were continued for an additional 14 days because of a severe iridocyclitis, continued nuchal rigidity, and low-grade fever. The convalescence was lengthy and complicated, but at the end of four months, she had returned to her pre-illness state without neurological residuals.

After much subculturing the offending organism proved to be Klebsiella pneumoniae.

Case II

A 90 year-old man had been under a physician's care previously with a severe weeping dermatitis of the legs, for which cortisone had been prescribed with excellent response two months prior to hospital admission. Due to misinterpreted orders he had continued to take 12.5 mgm. of cortisone four times daily for the four weeks before admission, although the original dermatitis had largely subsided.

Twelve hours before admission the symptoms of cough, dyspnea, rusty sputum, fever and prostration came on very rapidly. On admission he was seen to be acutely ill, and on examination showed a temperature of 101°, and an area of bronchial breathing with crepitant rales over the left lower lobe. The right lung was clear. A bedside chest x-ray confirmed the diagnosis of early consolidation of the left lower lobe, and antibiotic therapy was begun with NEOPENIL 500,000 units at 12-hour intervals. That the illness was an overwhelming one was evident from his state. Usually a bright, alert individual, he had changed in a few hours to a state of pre-coma drowsiness from which he could be aroused only with difficulty. He was incontinent and unable to cooperate in any way.

A specimen of sputum showed gram positive diplococci, which upon culture proved to be pneumococci. The type was not determined.

Because of the extreme toxicity and also because of the previous cortisone administration, it seemed logical to give full-scale cortisone therapy along with the antibiotic. A daily schedule of 400 mgm., 300 mgm., and gradually decreasing dosage on successive days was begun. The initial 24-hour period showed little change in his status, but the second 24 hours brought about a dramatic return to his usual cheerful, irascible state with refusal of medications by injection, insistence on mobilization, full appetite, and defervescence.

Cortisone administration was changed to the oral route, and dosage was rapidly decreased over a six-day period because of a sudden rise in blood pressure from normal levels on the fifth day of therapy. Physical and x-ray evidence of pneumonitis disappeared rapidly and were virtually cleared at the time of discharge one week after admission.

Case III

A white male, aged 93, with a past history of mild senile dementia was admitted to the hospital in a comatose state. He had had a cold and cough for three days, and had been unconscious for about 15 hours before admission.

Rectal temperature was 102° F., pulse, 110, blood pressure, 100/60. He was a frail individual with definite cyanosis. Evidences of pneumonia were present in both lung bases.

He was placed in an oxygen tent. Penicillin 100,000 U every four hours and cortisone, 100 mgm. every eight hours were given intramuscularly. Dextrose in Ringer's solution was given subcutaneously, and he was digitalized.

Nine hours after institution of these measures, he was fully conscious, sitting up in bed, saying he felt "fine," and taking food and fluids by mouth.

Twenty-four hours after admission, he was rather confused and a bit difficult to manage. He took soft foods well and was allowed to be out of bed for commode privileges. Cyanosis had cleared. Auscultation of the chest revealed no change from the first examination. It was not possible to gain his co-operation for chest x-ray or sputum examination. Cortisone dosage was reduced to 50 mgm. every eight hours.

During the next few days signs of consolidation in the lungs cleared, cough became more productive and fever declined. He became more confused and disoriented. Morphine sulfate in eight mgm. doses was required a few times to obtain quiet. Oxygen therapy was discontinued, and cortisone dosage was reduced to 50 mgm., later 25 mgm., every 12 hours. On the seventh hospital day cortisone was discontinued; penicillin therapy was continued.

On the twelfth day his lungs sounded relatively clear. A chest film made that

day showed evidence of pneumonic consolidation in the left lung. His temperature was normal. Though still confused, his mental state had cleared considerably, and he was tractable.

Convalescence was complicated by symptoms of prostatism. On the twenty-third hospital day, after preparation with 100 mgm. cortisone intramuscularly every eight hours and blood, transurethral prostatectomy was done. Cortisone was discontinued 36 hours following surgery. On the night following the prostatectomy he fell out of bed, but sustained no severe injuries. His further hospital course was uncomplicated, and he was discharged to a nursing home 37 days after admission.

Case IV

A 91-year-old female with mild diabetes and senile mental changes was admitted to the hospital with pneumonia involving the base of the right lung. Her temperature was 101°F. Erythrocytes numbered 2.5 million, hemoglobin 6.5 gms, leukocytes, 21,400, neutrophils, 80%. She was semi-conscious on admission.

She received cortisone 100 mgm. every eight hours, intramuscularly, and penicillin 100,000 units intramuscularly every four hours. Ten hours later she was drowsy, but not somnolent, and was as cooperative and rational as before her illness. Clinitest gave a yellow reaction; blood sugar was 382 mgm. per 100 cc. Regular insulin was given as indicated by the clinitest performed every four hours. She received 500 cc blood and took a free soft diet. She climbed out of bed during her nurse's absence and was found walking about the room, declaring she felt "fine."

Examination of the chest 48 hours after admission revealed evidences of clearing of the pneumonic process, and cortisone and penicillin dosage were reduced. On the third hospital day fever ascended to 102°, and cortisone and penicillin dosage were again increased.

Convalescence, from a physical standpoint, progressed smoothly thereafter. Penicillin and cortisone were gradually withdrawn, ACTH being given before final discontinuance of cortisone. Following cortisone withdrawal, glycosuria disappeared; and insulin was not required.

During cortisone therapy she was quite demented and combative, requiring morphine sulfate (8 mgm) at times to induce quiet.

She was discharged, ambulatory, to her home on the twelfth hospital day.

Discussion

Several features of these cases deserve comment, not the least of which is the fact that all patients survived what appeared at the onset to be terminal illnesses. Whether antibiotics alone would have effected recovery in any of them seemed doubtful when compared with similar previous experiences in aged patients. The uniform response with defervescence, clearing of sensorium to the pre-illness state, rapid gain in appetite, strength and well being was dramatic and could only be interpreted in the light of a remarkable suppression of all evidences of toxicity.

It is interesting to note that in Case IV a reduction in dosage of cortisone and penicillin was promptly followed by a relapse in fever which was again suppressed by resuming the previous schedules.

All patients had evidence of arteriosclerotic cardiovascular disease, but in none did the usual doses of cortisone jeopardize the welfare of the patient in any way.

The onset of an overwhelming infection in the nonagenarian who was taking small doses of cortisone illustrated the necessity of control of patients on steroid therapy. A dose of 12.5 mgm. four times daily was obviously inadequate to conceal the infection, and, conceivably, may have contributed to its activation.

Patient III, a mild diabetic, was readily controlled with small amounts of insulin and required none when cortisone was stopped. If diabetes mellitus were considered an absolute contraindication to cortisone therapy, this patient would have been denied its usefulness. Obviously, diabetes does not constitute contraindication to cortisone therapy in such a case.

Summary and Conclusions

1. Four cases of severe acute infections in aged persons are discussed.

2. The combined use of antibiotic and adrenal steroid therapy in these cases effected recovery when a fatal outcome was expected.

3. The exhibition of cortisone or ACTH alone in the presence of infection is a dangerous procedure; the use of these hormones in conjunction with *effective* antibiotics may be life saving.

Eye Injuries*

MERRILL J. REEH, M. D.

Portland, Oregon

Many of the injuries resulting from automobile and airplane accidents, and an ever expanding industry involve the eyes. They vary from minor to extensive wounds which may be associated with multiple injuries of the face and head. Much of the future success depends upon the effectiveness of the original treatment which is administered. The physician must determine the nature and severity of the injuries, and then decide whether his ability and facilities warrant attempting treatment beyond that of first-aid.

Orbit

The orbit acts as a bony cavity for the eyeball, permitting free movement, unobstructed passage of vessels and nerves, and affording maximum protection. Seven bones (1) take part in the formation of the orbit. The zygomatic (malar) bone forms a large part of the floor and lateral wall of the orbit.

Fractures of the zygomatic bone and zygomatic arch are next in frequency to fractures of the nasal bones. (2) Fractures may also involve other portions of the orbit, being at times associated with fractures of other facial bones, the paranasal sinuses and the skull.

When patients are encountered who have suffered multiple injuries and are in desperate need of care, the physician is often compelled to give life-saving treatment and limit his examination to a rapid appraisal of the injuries. Immediate inspection of the face and eyes will often be of value. The lids should be gently opened to permit a thorough inspection of the eyes when the patient is unable to do so voluntarily. Gentle palpation of the orbital rims and the cheeks will often suggest a fracture with dislocation of the zygomatic bone. Information obtained in this manner aids in making more accurate requests for x-ray studies. A thorough x-ray study should always be made if there is any suggestion of fracture of the facial bones. If inspection reveals the presence of ecchymosis of the eyelids and conjunctiva, it is well to consider the differentiation between a simple "black eye" and a fracture of the orbit with or without extension into the skull. Walsh (3) states that when the extravasations of blood are associated with fracture, the blood comes from the torn dura and bone and does not usually become visible for several hours or even for days after the injury. In many instances the lower lid contains more blood than the upper and often there is a "butterfly" distribution of the blood staining. The hemorrhage appears to be purplish in color. It also appears to be under the conjunctiva. The ecchymosis of the lids tends to be limited by the orbital margins. It is well to bear in mind that occasionally fractures of the orbital bone with hemorrhage will involve the optic nerve sheath producing partial or complete loss of vision. In case of head injury the pupils should be observed immediately and at intervals thereafter. Changes in size, shape, or reaction may indicate injury to the eyes, visual pathways or brain.

Exophthalmos and fixation of the globe in case of orbital injury suggest the presence of hemorrhage, a foreign body, or both.

Fractures of the zygomatic bone and other orbital bones, should be reduced immediately or as soon as the patient's condition will permit. Marked edema of the face and the pressing demands of injuries elsewhere may cause the physician to overlook a marked fracture-dislocation of the zygomatic bone. It is most unfortunate that late repairs of this disability are often quite unsatisfactory to the patient.

Lids

The lids are designed to moisten and protect the eyes. Failure on their part may prove disastrous within a short period of time. In general the lids may be considered to consist of two principal layers, the outer and the inner layers. The outer layer is composed of the skin and orbicularis muscle and the inner layer, the tarsal plates and adherent conjunctiva supported by the medial and lateral palpebral ligaments. The inner layer can be thought of as the skeleton of the lid. The two layers can be separated surgically at the white line which appears on the margin. (Fig. 1) (4)

Lacerations of the lids may be superficial or deep. They may or may not involve

*Presented at the Annual Meeting of the Kentucky State Medical Association, Louisville, Kentucky, Sept. 29, 1955.

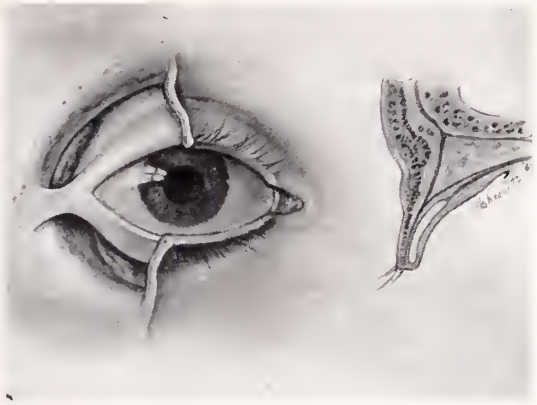


Fig. 1 The lids are composed of two principal layers. The outer portion, skin, and orbicularis muscle, and the inner portion, tarsus and conjunctiva suspended by palpebral ligaments. (4)

the margin of the lid. Deep lacerations often involve the orbital septum, levator palpebrae, superior oblique tendon, and even the eyeball itself. It is imperative that the physician determine the nature of the wound and above all the structures which require repair. To close only the skin and leave a levator muscle unattached or an eyeball wound unrepaired, is a most unfortunate oversight. The levator palpebrae can usually be identified and sutured into position when the laceration is fresh, thus preventing future ptosis, but a wound which has healed often presents an impossible barrier to adequate identification of the muscle and correction of the ptosis. The lid wound may also involve the tear duct (canaliculus), especially the lower one, which is the major source of drainage of tears into the nose. (Fig. 2) This should be recognized and the duct repaired immediately. Early repair offers a reasonable chance of success, whereas late repair usually results in failure.

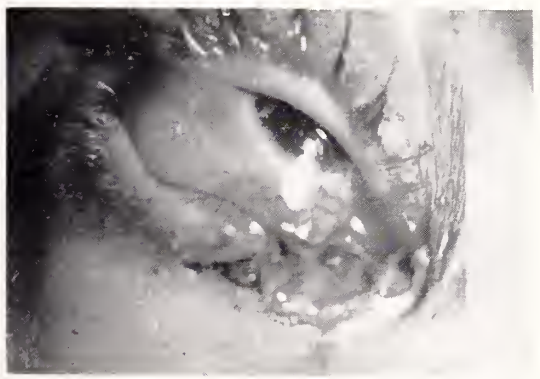


Fig. 2 Laceration of the lower lid with involvement of the lower tear duct. (Courtesy Lt. Col. John Edwards, U S Army, MC)

Lacerated wounds of the lids involving the margin may demonstrate horizontal or vertical tensions. Failure to correct vertical tension may result in a deformity in which the lids fail to close. Extensive wounds of the lids in which tissues have been avulsed, often manifest vertical tension after repair. Intermarginal adhesions which are permitted to remain until the contraction has subsided will usually prevent this deformity. Uncorrected horizontal tension will result in the formation of a notch. A notch is not only unsightly but may result in exposure of the cornea. (Figs. 3 and 4)



Fig. 3 Deep lid laceration with resulting vertical tension.

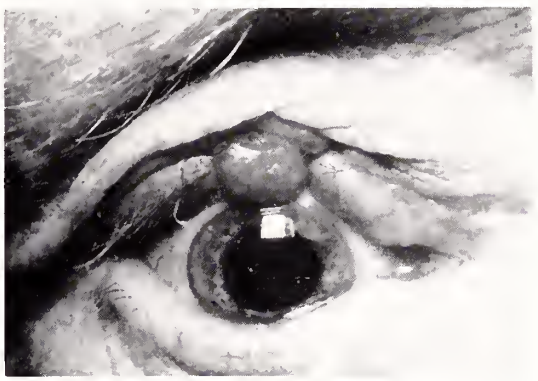


Fig. 4 Complete laceration of lid with horizontal tension. Wound was closed improperly, horizontal tension was uncontrolled resulting in separation and formation of a notch containing granulation tissue.

Lacerations of the lids involving the margin should be closed layer by layer after a carefully placed marginal suture has been inserted. (Figs. 5 and 6). If the repair of these wounds requires more than a simple closure it is wise to obtain specialized assistance at once.



Fig. 5 Vertical laceration of entire lid with horizontal tension. Perforating wound of globe with retained metallic foreign body complicated this wound.

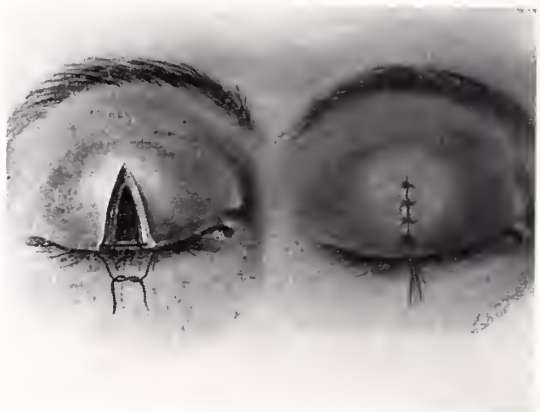


Fig. 6 Closure of complete laceration of upper lid. Marginal suture inserted, followed by closure of the two principal layers of the lid with interrupted sutures.

In case of lacerations of the lids, preoperative care is highly important. The wound should be meticulously cleaned removing all foreign matter and debris. Soap and water, saline and hydrogen peroxide may be used. It may be necessary to remove gross foreign matter and debris mechanically. Hemorrhage should be controlled. The possibility of tetanus should not be overlooked especially if the wounds are deep or badly contaminated. In the case of small wounds, 1500 units of antitetanic serum may be sufficient. Larger wounds will require 3,000 units or more, to a total of 6,000 to 10,000 units given in 3,000 unit weekly doses. Tetanus toxoid may be administered when applicable.

There are certain surgical principles which should be considered in the repair of lid lacerations. All lid tissues must be handled with extreme gentleness. Debridement must be sparing, removing only devitalized or necrotic tissue. The lids have an excellent blood supply, thus permitting many severely injured tissues to survive. Ocular tissues are limited; sacrifice them wisely. In case of avulsion or severe lacerations of the lid corneal exposure must be prevented. The remaining lid or a skin flap may be sutured to the opposite lid for protection until repair can be made. The wound should have smooth edges which are vertical to permit accurate closure. The tissues must be free so that the wound can be closed *without tension.* Delicate lid tissues undergo necrosis and separate before healing is firm if undue tension exists.

Closure of lid wounds should be layer by layer, that is the two principal layers of the lid, restoring the anatomy to its original state. Hemostasis should be complete since clots interfere with good healing and often lead to excessive scar formation. It is well to use fine suture material, preferably No. 000000 silk. Tension may be prevented by closure of subcutaneous structures with fine catgut prior to insertion of skin sutures. A simple skin suture in which the needle is passed through the skin into the apex of the wound and brought out and then passed into the apex and up through the skin of the opposite side, making the maximum tension on the corium is considered ideal for closure of the skin in lid and face wounds. Skin sutures should not be tied too tightly. As a general rule skin sutures are removed in five days. When silk sutures are used in the tarsus they should not be removed for seven or 10 days because this firm connective tissue heals slowly. Prompt, gentle, aseptic closure of lid wounds will do much to prevent infection. Antibiotics may be used when deemed necessary.

Globe

Injuries of the globe are either perforating or non-perforating. The pathologic changes are due to the injury itself or the complications which may follow. Non-perforating injuries of the globe are frequently encountered and usually are minor in nature. The contusion, however, occasionally produces severe ocular injuries.

Foreign Body

Loose foreign bodies or those imbedded in the cornea cause immediate symptoms. A careful examination should be made, using good light and magnification afforded by the loupe. The upper lid should

be turned and a careful search should be made for presence of foreign bodies. Imbedded foreign bodies located in the cornea can usually be discovered in good light with magnification produced by the loupe. On rare occasion, a tiny imbedded corneal foreign body requires study with the biomicroscope and slit lamp. Removal of an imbedded foreign body requires good light, magnification, a proper instrument, preferably a golf stick spud, and adequate local anesthesia. I prefer OPHTHAINE .5% or TETRACAINE .5% making two instillations prior to surgery. When the foreign body is removed, one should support one's hand on the forehead or cheek so that the touch can be light and properly controlled. The foreign body should be lifted from its bed and not scraped away causing considerable injury to the epithelium and stroma. If rust is present, it can be removed by gentle scraping of the margins of the foreign body crater. If the rust does not come away readily an attempt on the following day will usually prove successful. After the foreign body is removed, it is rarely necessary to instill atropine or scopolamine. Ointments should not be instilled into the eye following the removal of a foreign body. ISOPTO-CETAMIDE, sodium sulfacetamide or GANTRISIN may be instilled into the eye prior to the application of a dressing. A firm dressing should always be employed. The eye should be dressed until the wound is covered with epithelium. Medication should be made available to the patient to prevent pain following the removal of the foreign body. If this is not done the patient may believe that the foreign body has not been removed.

Because of the possible claims which may be made at a later date, it is advisable that a careful history be obtained and recorded. The visual acuity should be recorded. Careful examination should be made of both eyes to determine the presence of disability due to previous disease or injury. Unfortunately, many claims are difficult or impossible to evaluate because of the absence or inadequacy of records pertaining to the original injury. (5)

Abrasion

Corneal abrasions are commonly encountered. The patient immediately offers the history of having been struck in the eye by an object. After a careful search is made to rule out the presence of a loose or imbedded foreign body, it is well to stain the cornea with fluorescein. This will produce a green stain wherever the epithelium has been detached. Because of the possibility of contamination of fluorescein with pseudomonas aeruginosa (pyocyaneous) it is best to use solutions which are prepared commercially. One or two drops of local anesthesia are used prior to the application of the dressing. The patient should be given adequate medication to control pain. The dressing should be maintained until the epithelium has healed to prevent immediate or late complications. Under no circumstances should a local anesthetic be prescribed to the patient. Improper use of these drugs by the uninformed patient may prove disastrous.

Burns

The eye may be burned by fire, hot liquids, chemicals, or actinic rays. First aid treatment is extremely important. The pain should be controlled if it is severe. All debris should be removed by irrigation. McLaughlin (6) advises irrigation at the scene of the accident and later in the office. He does not recommend the use of alkalis or weak acids and states that at times they may prove to be harmful. In case of alkali burns, the eye should be irrigated for 15 to 20 minutes. All visible particles of alkali should be removed immediately. After adequate irrigation of the eye fluorescein should be instilled to determine the extent of the burn. A mydriatic (atropine or scopolamine) should be instilled and a dressing applied. Alkali burns which show definite stain with fluorescein indicate destruction of tissue and, if possible, should be referred to an ophthalmologist. They tend to be more severe than their original appearance indicates because of the delayed activity of alkali. There is often a sloughing of the cornea and conjunctiva with subsequent scarring and the formation of symblepharon.

Experimental studies showed several forms of calsulfhydryl (hydrosulphasol) in treatment of acid burns of the cornea to be of no benefit and in alkali burns of the cornea to have a deleterious effect. (7)

Actinic burns (welder's flash) are usually painful but seldom result in permanent damage. One should examine the eye carefully for the presence of a foreign body despite the insistence of the patient that he has suffered only a "welder's burn." Local anesthetic should be instilled and adequate medication dispensed for the control of pain. Do not dispense a local anesthetic or condone the use of this on the part of the patient.

Contusion

The pathologic changes resulting from a contusion depend upon the force of the blow and the ability of the structures to withstand it without tearing. All ocular tissues are subject to injury by contusion. (Fig. 7). When one considers the extent and the variability of the injuries which may result from a contusion, it is quite evident why a careful examination should be made and adequate treatment administered. All eyes which have been injured by contusion should be carefully examined at the completion of treatment. Hyphemia (hemorrhage into the anterior chamber) will be encountered frequently. (Fig. 8) It may consist of a small amount of blood in the aqueous or the presence of a huge black clot. If the hemorrhage is small, it will usually absorb rapidly. The patient should be compelled to remain quiet for three to five days to avoid the development of continued hemorrhage and secondary glaucoma, which if inadequately controlled, may lead to the destruction of an otherwise useful eye.

Perforating Injuries

All perforating injuries of the globe are serious emergencies. They require immediate specialized surgical care. A wound into the eye with prolapse of intraocular contents constitutes an emergency similar to that of an abdominal wound with a prolapse of intestine. Every hour is precious, the longer one delays surgical repair, the greater the hazard to the eye. (5) Ointments should not be instilled into the eye. A light gauze dressing should be applied. The patient should be given adequate medication for pain. Antibiotic medication is frequently indicated. If there is any need for protecting the globe a cardboard or metal shield can be placed over the dressing.

A careful history should be obtained. In case of the pounding of steel on steel, or injury by explosion or gunshot, one should be highly suspicious of a foreign body within the eye. (Fig. 9) Usually the wound of entrance is visible and obvious. However, there is always the possibility of a small metal foreign body entering the eye through the sclera and leaving an almost imperceptible wound of entrance. If there is any possibility of an intraocular foreign body an x-ray should be made. If a foreign body is found, accurate localization should be made and immediate attempt at removal carried out. (Fig. 10.)

Lacerations of the cornea and sclera must be repaired immediately with fine



Fig. 7 Contusion resulting in iris being torn away from the ciliary body producing irregular, partially fixed pupil. (Courtesy of Lt. Col. John Edwards, U S Army)

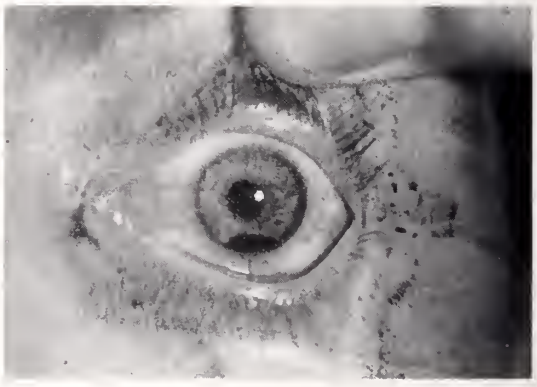


Fig. 8 Contusion from land mine resulting in hyphemia. (Courtesy of Lt. Col. John Edwards, U S Army)



Fig. 9 Perforation wound with retained metallic foreign body resulting from pounding hammer on steel shaft. Small perforation through cornea and lens into vitreous chamber. F. B. removed with magnet and cataract extracted at later date.

suture material. Closure with a conjunctival flap alone is no longer acceptable This improvement in ophthalmic surgery has resulted in the retention of many useful eyes. (Fig. 11)

Sympathetic ophthalmia is always a possibility in case of perforating wound of the globe. It is one of the tragedies feared by every eye physician. It occurs more often in younger individuals, appearing between one and three months after the injury. The incidence of sympathetic ophthalmia can be reduced by immediate surgical closure of wounds and adequate after care, proper handling of intraocular foreign bodies, and the immediate enucleation of hopelessly injured eyes. Cortisone and ACTH have aided in the treatment of this disease. Despite the availability of these drugs for treatment, it is best that sympathetic ophthalmia be prevented.

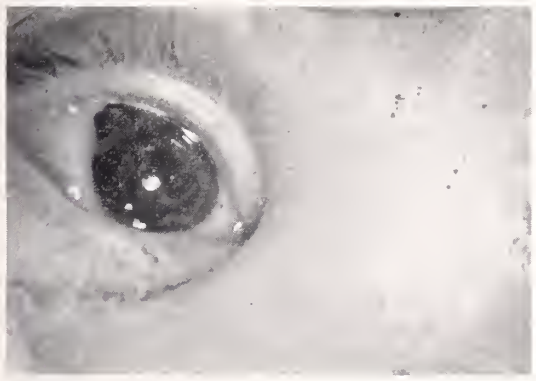


Fig. 10 Perforating wound with retained metallic foreign body resulting from fragment of high explosive shell. Hyphemia present with prolapse of iris and lens capsule. (Courtesy Lt. Col. John Edwards, U' S Army)



Fig. 11 Perforating wound of cornea, closed only with conjunctival flap. Resulted in failure to heal and loss of the eye.

Summary

1. Fractures of bones of the orbit, especially the zygomatic bone, are frequently encountered. The presence of a fracture should be determined immediately and the reduction made without delay in order to prevent serious deformity of the face and/or ocular disability.

2. Lid wounds may be superficial or deep and may involve numerous structures. The nature of the wound and the structures involved must be determined before treatment is instituted. Repair should not be started unless it can be carried out properly. The basic principles covering the care of lid wounds should be employed. The physician must not overlook a perforation of the globe when treating a lid wound.

3. Wounds of the globe are either perforating or non-perforating. The pathologic changes are the result of the injury itself or the complications which may follow.

4. Non-perforating injuries are usually minor in nature; however, there may be notable exceptions, as some burns and contusions.

5. All perforating injuries of the globe are serious emergencies and require immediate surgical care.

REFERENCES

1. Wolff, E.: The Anatomy of the Eye and Orbit, Philadelphia, Pa., The Blakiston Company, 1940.

2. Callahan, Als'on: Surgery of the Eye: Injuries, Springfield, Ill., Charles C. Thomas, 1950.

3. Walsh, F. B.: Clinical Neuro-Ophthalmology, Baltimore, Md., The Williams & Wilkins Co., 1947.

4. Reeh, Merrill J., and Browning, Charles W.,: Reconstructive Surgery of the Lids and Conjunctiva, Trans. Pac. Coast Oto-Ophthal. Soc., p. 101-125, 1954.

5. Reeh, Merrill J.: Eye Injuries, Northwest Medicine, Vol. 48, No. 6, June 1949.

6. McLaughlin, R. S.: Chemical Burns of the Human Cornea, Am. J. Ophth., 35: 1088 (Aug.) 1952.

7. Bahn, G. C. and Allen, J.: Therapeutic Studies in Experimental Chemical Injury of the Cornea, Am. J. Ophth., Vol. 54, No. 1, July 1955.

The Case For Social Medicine*

PETER L. SCARDINO, M. D.

Savannah, Georgia

If I understand correctly the invitation which brought me here, I am expected to bring to your attention some of the social problems which confront the medical profession and perhaps, with humility, offer possible measures to overcome these difficulties. If we were to view the history of American medicine of this century as a circle, then the circle might, for the sake of clarity, be divided into three segments. Beginning with the year 1900 and extending to about 1935 we will label this 120 degree sector of the circle the Golden or Halcyon period. The second segment of our "Public Relations" circle, 1935-1950, we will call the Scientific sector. And the last 120 degrees, from 1950 into the future, we shall call the Olympian or Heroic sector. How we shall attain this final goal is the purpose of this paper.

Organized American medicine has experienced a metamorphosis during the past 50 years. At the turn of the century no one in the community enjoyed greater prestige than the family physician. While he had serious problems, getting along with his fellow citizens was not one of them. He had been among the first citizens since the signing of the Declaration of Independence. For on this historical document appear the names of six physicians among the 59 patriots. Now, having established that the physician of the first quarter of this century and before enjoyed the best of good public relations, let us proceed to the next sector of the circle.

Scientific Medicine

In 1935 chemotherapy as we know it was introduced. This date has been arbitrarily selected as the pivotal point of scientific medicine. Following the Flexnor report in 1915 the medical schools of America embarked upon a program of improvement which is still continuing. No one can question the results brought about by this change in American medical education providing one limits the search to scientific accomplishments.

There resulted from this headlong plunge into greater scientific development and improved medical education a product which the medical schools persisted in labeling Doctor of Medicine, but this was certainly not the horse and buggy graduate of the earlier schools. Better trained, yes! But better educated? We shall see. The 1935-1952 graduate was equipped to cure the ills of his patients in a manner never dreamed of by his predecessors but what the price would be of this purely scientific program, few could predict. There were of course those giants of medicine, Osler, Welsch and others who warned of the potential evils of training men to treat patients as if they were mice; diseases were treated, not individual people. Medicine gained a foot but lost a yard, if one were to take into account the problems produced. And this loss was cumulative as we passed the 17 years of 1935-1952. Our well-trained scientists, lead by even better trained professors, continued to devise even greater means of curing patients of mental and physical illnesses. Did we not have justifiable cause to be pleased with ourselves and our scientific advances? Indeed we did. Each year, throughout the country, we were contributing in no small measure to the decrease of infant mortality. In a few years we had added almost a decade to the life span of every American—even with the destructiveness of the automobile. But what had we not done. As we cured people with our scientific coolness we lost warm friends. How could this be? We saved more babies, we rescued more mothers, we prolonged the lives of so many; yet by 1949 we had fallen so far in the hearts of our countrymen that an expert hired by the AMA to survey the public relations of American doctors concluded that they were bad, and he resigned with the statement that unfortunately the policies of American doctors were more closely identified with their economic interest than with the patient's welfare. Such a charge could not have been made prior to 1935. No one would have dared to publish such heretical ideas. The American public and the American doctors had been identified as one, but in the past 20 years they have found themselves worlds apart.

Change from Halcyon Days

Because of the good public relations which existed from 1900-1935 we called this the Halcyon sector of the circle. The

*Presented at the Annual Meeting of the Kentucky State Medical Association, Louisville, Kentucky, September 29, 1955.

second segment, 1935-1952 we shall call the Scientific sector. In the Halcyon days we reveled in the practice of medicine as it was then known. We gave ourselves and our time because our knowledge was limited. In turn we were revered, idolized, enshrined, worshipped and loved. As we advanced into the second sector, these tender words somehow failed to apply to us. We substituted training for education; long life for a full life; penicillin for prayer; and in so doing lost what both the patient and the doctor of the previous age treasured most: the warmth of a human relationship based on need and service and essential kindness; the satisfaction of carrying out the Biblical command to visit the sick and comfort the afflicted.

As a result of the cost of our training programs in time and money we sacrificed the humanities for the sciences; Hume for Halsted; the classics for Cushing. Where did the new leadership take us? By 1952 and perhaps earlier, we found ourselves so specialized and so well-trained that we wondered if there was actually anything scientific we could not do. Cures for cancer, polio, and TB were heralded as being just over the horizon. We had become so good as specialists that we decided we would remove the last vestige of the Halcyon days and make pure scientists of all doctors. The general practitioner was encouraged to become a specialist in "general practitionering" and he is probably the only doctor in the country with a first-class patient relationship. At last everyone was encouraged to become a cool specialist. Now we find ourselves one great group of over 200,000 precision-trained, full-torque, poorly-educated but superbly trained scientists. We can cure in five hours what it took ten days for the physician of the Halcyon period to cure. Does all this add up to an indictment, a criticism, a fault, or a derogatory evaluation of our scientific advancement? Not at all. It is a statement of how things seem to me. It would be foolish indeed to belittle the great contributions of the years just passed. I would not change or suggest a single deviation from the progress made. Presumptuous indeed would be the man who would challenge the wisdom of those who set us on this path. The profession should be justly proud of its scientific achievements and its most avid critics find no fault with these accomplishments. But medicine's preoccupation with science has left it exposed to the criticism that it has not kept pace with the vicissitudes of the social order. How can medicine be integrated with social technology? How can we regain the prestige of the Golden, Halcyon period and yet retain the sweeping advances of the scientific era? What a magnificent period we will enjoy when we enter that third sector of the circle which should be a blend of the first two. And I believe I see on the horizon forces already at work which will be the catalyst to fuse the old and the new into the future Olympian period. The beginning of the fusion and transmigration is in the local, state and national societies. Your own bluegrass state of Kentucky is in the forefront of this movement. Witness this very meeting which has brought so many of you from your daily labors to learn of this Renaissance. You have unselfishly added to your already overburdened careers a new responsibility. This meeting is a reflection of the advance into the third sector of medical progress in this country. During the time which it will take to complete the circle, which I think will be less than 25 years, we will approach the Halcyon period with the type of medical practice previously unknown. By substituting modern concepts of community living, civic consciousness, and citizen responsibility for the attributes of our medical forebears, we can meet the challenge of the change in social philosophy. These changes have exerted an enormous effect upon the medical profession and the public's attitude toward this profession. Once we have found the secret of combining these modern social concepts with the scientific advances we will have entered upon a phase of American medicine which will be a source of pride to future generations. We cannot retrogress. We cannot recapture the type of relationship which once existed between the horse and buggy doctor and his public. We must accept what we are and what we have. Modern medicine is a spectacular asset which we must apply to our problems, overcoming the obstacles.

Ways to the Olympian Period

What are the methods which we shall employ to attain this goal? Successful measures have been undertaken by many county medical societies. At the grass roots the stage for regaining our good public relationship has begun. Thousands have attended free public Medical Forums with which you are familiar and even more thousands listen to similar programs broadcast via radio and television. But the demand for community participation by the physician is always present; the

Community Chest, the Chamber of Commerce, Red Cross, Church activities and public health campaigns are a few. Regular newspaper health stories and lectures in the schools of our communities have elicited a favorable response. All of these are actually responsibilities which we assume when the Hippocratic Oath is taken. The care of the indigent and attendance at Free Clinics are all parts of a physician's responsibility. These are obligations which he assumes and performs as a part of his duty as a member of this age-old profession. The intelligent functioning of the county medical society helps to hold in check the headstrong revolutionary; but grievance committees, emergency call service and effective public relations committees apparently fail to take us far enough into the third sector in this March of Medicine.

We have gained in areas of house cleaning. Euthanasia, unnecessary abortions and unnecessary surgery have come under the careful scrutiny of newly appointed committees. Much prestige is gained when the leaders of our communities hear that we are policing ourselves. In Savannah we have just been through a most disagreeable ordeal. A fellow physician brought suit against 14 of the leading medical men of our city. When they had made it impossible for him to operate in the last hospital in which he had privileges, he publicly accused his colleagues of conspiracy. In his seven million dollar suit, 5 weeks of protracted insults were leveled against 14 men of integrity. Throngs of Savannah citizens attended the trial. More newspaper space than any event since Oglethorpe climbed the bluff for the first time was devoted to this bitter experience. I mention this trial not so much because the honest physicians won over their adversary or because justice triumphed, but because out of the agony and torment and the expose of the personal lives of the defendents came a healthy response on the part of the Savannah Public. These 14 men took it upon themselves independently and without the assistance of any organized medical group to remove from our community a colleague who they knew was engaged in unethical practices. Knowing full well that they themselves would be subjected to all the insults of a clever attorney, they made it impossible for the culprit to perform surgery in the only hospital in which he had privileges. He in turn sued these honorable men for seven million dollars—claiming they had conspired against him. If any award were possible or national recognition given, these men whose good names were in jeopardy and whose expenses were over $25,000 should receive the personal thanks of every physician in America. This was a great effort but we can expect no less from members of this great profession. It is this type of courageous action which the public understands and which it expects from the medical community.

Public Duty

The practice of medicine is a public duty. Medicine cannot escape being social medicine. The doctor has always been "clothed with a public interest;" "He has been licensed for centuries"—he has never been allowed to refuse his services or plead caveat emptor. The doctors' only sacred relationship—like the priests', the teachers', and the lawyers'—is to his profession; and what makes a profession a profession is that it professes something, namely, the obligation of its practice. The doctors' profession obligates him to heal the sick, at any cost, at all cost, or at none, though the heavens fall, the landlord evicts, the shoe store replevins and the Kentucky Gas Company shuts off the fuel.

But it is not only these things of which the third sector of the circle must consist. It is rather that we as physicians advocate something positive—medical a c t i o n. Should we not act at this time, we shall find ourselves the victims of our own inertia, for as Edmund Burke said, "All that is necessary for the triumph of evil is for good men to do nothing." I fear that for too long, we did nothing to meet the challenge of the economists who accused us of so many wrong doings. We have always found ourselves fighting a rear-guard action—always against—opposing; perhaps a bit antagonistic. First we opposed group practice; then group insurance; and at one time I am informed that any type of prepaid insurance was anathema to private practice. In spite of the honest efforts of many brilliant medical economists and attorneys we have been losing the battle. Currently we find ourselves opposed to the reinsurance plan suggested by the present Washington administration. Of course we cannot subscribe to every proposal of bureaucrats nor should we fail to support decisions of our national medical leaders. But what I do suggest is that the intelligent leaders of our national and local medical organizations formulate a plan which can be understood by all and

immediately effective. Instead of chasing down the street to catch the bandwagon just before it lumbers out of sight, I should like to see the doctors of this country build the biggest brightest bandwagon ever made, complete with steam calliope, and put it into immediate service.

Conclusion

When I began to gather material for this talk, I had in mind roughly what I wanted to say. But in looking over magazines, books and newspapers and trying to get my perspectives straight from the layman's viewpoint, I came to an unexpected conclusion. The Brooking's Institute states that four per cent of the average person's budget is spent on medical expenses. I had to accept the fact that some patients literally cannot afford to get well. The judgement was forced on me that the patient's medical expenses are the essence of the fractured public relations picture we see today. Since I am not an economist I will not impose my ideas on you. I rather expect we shall hear later the solutions to these economic problems. The spokesman for American medicine in this day and age is organized medicine and it is to this group, both on a local and national level, that the public looks for leadership and guidance. We cannot, we dare not fail them, for we are responsible for helping them with this problem just as we are responsible for helping them with their gall bladders and their cancers.

Oral Surgery Cases of Interest to the Physician*

FRANK B. HOWER, D.D.S.**

Louisville

As a member of the dental profession who has enjoyed a harmonious working relationship with so many members of the medical profession, I am convinced there is a definite place for the Oral Surgeon as a part of the total health team.

We as dentists have been trained in a field that has held little interest to the physician. In fact, no school of medicine provides a course of study in pathology or surgery of the oral cavity. On the other hand, the student of dentistry is provided the same courses in the basic sciences as is the student of medicine. The same opportunities are available for advanced training through well organized and approved internships and residencies in most of the larger medical centers in this country and Canada. Virtually every large hospital has an oral surgeon as a member of the surgical staff.

The oral surgeon through his years of training and his work in the oral cavity possesses a unique skill and ability to carry out surgical procedures in the mouth. Dentistry has historically pioneered in this field.

Most orthopedic surgeons refer all jaw fractures to the oral surgeon. This is due to a realization that dentists possess a specialized knowledge of occlusion and normal jaw function. Also a higher percentage of mandibular and maxillary fractures may be successfully handled by the oral surgeon using intra-oral rather than extra-oral operations, thereby reducing the incidence of incisions about the face and resultant scarring.

The dental profession also has a knowledge of prosthetic appliances adaptable to this specialized field. Naturally a better result may be expected than from one whose interest and training has been in a broader field.

Today, oral surgeons are being called upon to advise and co-operate in the diagnosis and surgical treatment of malignancies of the mouth. Certainly in these cases there should be a co-operative approach by both professions. Illustrative case reports in support of this thesis will follow.

Case Report I

I would like to present a case of a man 47 years of age who had been operated on for a small carcinoma of the soft tissues of the mandible.

Following the operation, he was irradiated with deep x-ray. An unerupted molar and a root fragment remained in the jaw and a severe radiation necrosis resulted. There were many months of severe and constant pain from the necrosis. Unlike necrosis from infection this takes many months to sequestrate.

I do not believe that radiation therapy should ever be used in bones where teeth

*Presented at the Kentucky State Medical Association Annual Meeting, Louisville, Kentucky, September 27-29, 1955

**Secretary-Treasurer of the American Society of Oral Surgeons.

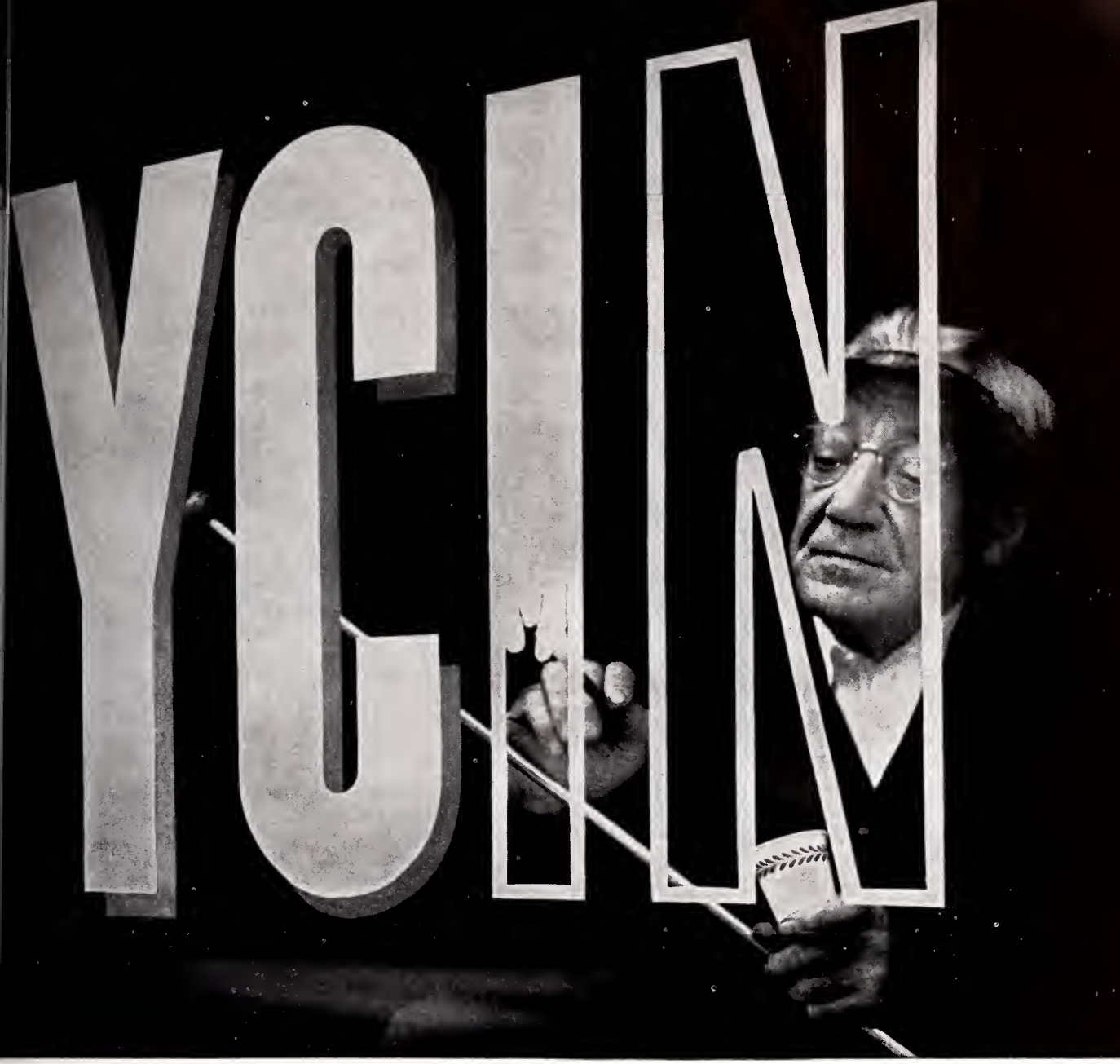


PHOTO DATA. CAMERA: 4X5 VIEW CAMERA; EXPOSURE 1/25 SEC. AT F.11 EXISTING LIGHTING.

ACHROMYCIN*

Hydrochloride

Tetracycline HCl *Lederle*



widely prescribed because of these important advantages:

1) rapid diffusion and penetration
2) prompt control of infection
3) negligible side effects
4) true broad-spectrum activity (proved effective against a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa)
5) every gram produced in Lederle's *own* laboratories under rigid quality control, and offered *only* under the Lederle label
6) a *complete* line of dosage forms

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* PEARL RIVER, NEW YORK

Lederle

REG. U. S. PAT. OFF.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1956 Annual Meeting Kentucky State Medical Association

Columbia Auditorium **Louisville, Kentucky** **September 18, 19, 20**

Fill Out and Mail to:

EVERETT L. PIRKEY, M. D., Chairman

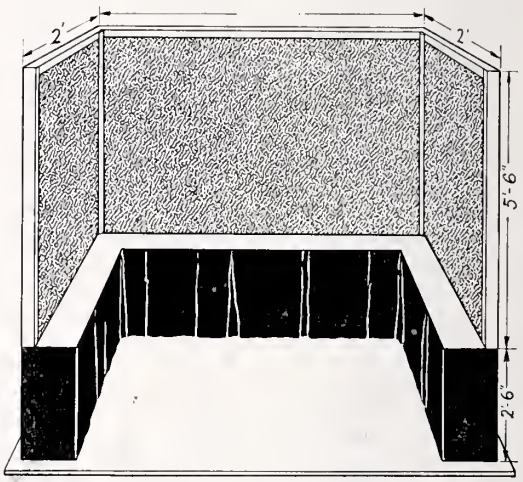
Committee on Scientific Exhibits

Louisville General Hospital,

Louisville 2, Kentucky

(Applications for space should be received before July 1, 1956)

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

are present. In all cases, pre-operative x-rays should be made and all teeth and roots in the area of radiation should be removed before therapy is begun.

Salivary Gland Calculi and Bone Cysts

Through a comparatively recent technique, it is possible for the dentist or oral surgeon, whose equipment is better suited, to show calculi or stones in the submaxillary and parotid glands as well as the ducts. Many of these can be diagnosed and eradicated before more serious conditions result.

In all cases in which there is a prolonged enlargement in these areas, a complete x-ray examination is indicated. In any swelling or enlargement in the maxillary or mandibular bones, naturally a tooth is suspected of being abscessed.

It is not wise to depend upon a brief history and clinical examination. Too frequently there may be a bony cyst with marked destruction of the osseous structure. Occasionally adamantinomas are found.

Case Report 2

A sixteen year old boy presented with acute pain and swelling in the angle of his left mandible. His history was negative except that he had noticed a peculiar sensation in the left mental area of his mandible for six months and a gradual enlargement in the buccal plate of his mandible. Radiographic examination revealed a large follicular cyst extending from the mental foramen posteriorly to the ascending ramus and from the crest of the alveolar ridge to the inferior border of the mandible. The fluid pressure from the cyst had displaced the undeveloped third molar bud to within one or two millimeters of a complete pathological fracture.

Due to the hazards involved in attempting surgical enucleation, it was deemed advisable to use a modified Partsch operation. An opening was made into the cystic cavity sufficiently large to permit placing an acrylic tube. This was wired to a tooth to afford anchorage. As soon as this fluid pressure was relieved, the bone began to regenerate and the tooth bud moved up to normal position for eruption.

The patient went away to college and did not return for a periodic check up until four years later. Radiographic examination revealed a recurrence of the cyst but with much less destruction of bone. The two teeth in the area were removed and the cystic membrane enucleated. Six months later radiographs revealed a complete healing and regeneration of bone.

Case Report 3

This patient, four months pregnant, gave a history of extreme nausea, pain and trismus in her right mandible. Clinical examination revealed a partially erupted lower third molar without evidence of localized pain or soreness. Radiographic examination showed deposits of many calculae in the area posteriorly and lingually to the third molar.

Several prominent physicians and oral surgeons were consulted as to a possible diagnosis. The patient was referred to two outstanding men in another city. The result was a thorough clinical and x-ray study but no diagnosis—only a request that the patient return in six months for further examination.

Later, in conversation with a group of doctors, this experience was related. One of the group, an eye, ear and throat surgeon asked who the patient was. Upon being told, he related the fact that about a year previously he had removed this patient's tonsils without incident but following the tonsillectomy he removed a small out-cropping of soft tissue posteriorly to the third molar and experienced marked difficulty in controlling the hemorrhage. Examination of this tissue revealed a hemangioma. Further consultation with radiologists suggested the possibility that the lesion was a calcifying hemangioma and the areas of density shown were phleboliths. Reports of this condition are very rare in medical and dental literature.

Systemic Conditions

There are numerous systemic conditions, especially those of a debilitating nature in which symptoms appear early in the oral cavity. There are often marked changes in the color and appearance of the mucous membranes. There may be gum hyperplasia, gingivitis, bleeding and color variations. These conditions are especially true in the blood dyscrasias.

It is not uncommon to find a patient with one of the anemias. They are usually characterized by very pale mucous membranes and in some cases intermittent bleeding.

The purpuras are also seen by the dentist. These patients, usually children, show areas that appear to be bruised and may bleed rather profusely at times.

Hyperplasia of the gingivae is an early symptom in monocytic leukemia and occasionally in other types. Bleeding of the gums is also a common symptom. Too often dentists extract teeth in undiagnosed cases of leukemia and discover difficulty in the control of hemorrhage. Most of these cases bleed intermittently for several days to two or three weeks.

In all suspected cases, a complete blood examination should be made. When this examination is made, it should include bleeding and clotting time, platelet count and prothrombin percentage and activity.

There are many patients with circulatory diseases today who are taking Dicoumarol and other anti-coagulants which affect the prothrombin activity and produce severe bleeding following the extraction of teeth or other minor surgical procedures.

Any patient taking anti-coagulants should be advised of the possible complications. Usually the prothrombin will return to normal activity within seven to ten days after the administration of the drug is stopped.

Also, among the hemorrhagic disorders seen are those of an acquired nature at times associated with liver disease. These may show purpura in the hands, face or mouth. Bleeding of the gums in these cases is usually due to prothrombin deficiency.

Any patient with a history or symptoms of blood discrasia should have a thorough physical examination by the physician, including careful blood studies.

English workers have shown that even the hemophiliac may show a normal bleeding and clotting time. If the examination is limited to this procedure alone, the evidence is not sufficient to determine the patient's ability to form a normal clot.

Case Report 4

Within recent weeks a man of 69 came to my office for the removal of five teeth. He gave a history of having had a tooth extracted three months previously, followed by intermittent bleeding for six days. I was advised by his physician that he had been under treatment and that his bleeding and clotting times were within normal limits.

Following the removal of two of the five teeth, the patient was again unable to form normal clots. This bleeding was intermittent for eleven days. A more complete blood study revealed the following: Prothrombin activity 32.5 per cent; prothrombin time 18 seconds; platelet count of 63,300. The patient was referred to a hematologist. The resultant diagnosis was lymphatic leukemia.

No physical examination is complete unless it includes the oral cavity. Not only may a neoplasm be observed but frequently there will be found such predisposing factors of malignancy as leukoplakia and fractured or carious teeth. It is an appalling fact that so many of our people neglect hygiene of the mouth and carry chronic infections for years because of ignorance, fear and indifference. The general health of these people could be vastly improved and perhaps their lives prolonged if they were educated by their family physician and dentist to the importance of mouth health in the maintenance of a sound body.

A Method of Treatment of Alcoholism and the Results*

WILLIAM B. TERHUNE, M. D.***

New Canaan, Connecticut

Alcohol addiction is a serious medical problem; it kills thousands and cripples millions. The consumption of alcohol in the United States has increased thirty per cent in the past ten years and more than a billion dollars each year is spent on it. There are 65,000,000 who drink regularly**, of which figure 4,000,000 are now problem drinkers. There are in this country 15,000,000 potentially abnormal drinkers.

Alcoholics suffer from a disease as malignant as cancer, since it destroys body and spirit. Physicians mince no words diagnosing a malignant growth, and patients lose no time in having it treated. Since alcoholism is malignant, it is every doctor's ethical responsibility to tell the patient who drinks abnormally: "You are an alcoholic, in need of adequate, immediate, and drastic treatment. Furthermore, it will never be safe for you to use alcohol in any form."

The alcoholic may question this diagnosis and seek consultation, hoping for an answer more to his liking. Medical ethics demand that all physicians support this diagnosis and recommendation, without equivocation. They should remember how deceitfully persuasive alcoholics are. The patient must not be allowed another leg of equivocation to stand on; he is already a psychological centipede. Give the alcoholic an inch of evasion, and he takes all. Often when a doctor says, "You are not really an alcoholic," he has not investigated carefully, does not know what an alcoholic is, or prefers not to make an enemy. The factual attitude on the part of the medical profession is essential to securing and maintaining successful treatment.

We doctors know that the drinking alcoholic is a danger to himself, his family, and his associates; that he lies, is deceitful, and is often immoral, irresponsible, and unethical. He induces family and friends to lower their moral standards by their lying to conceal his alcoholism to protect him from censure. As a result of excessive drinking, he often becomes a tyrant, whom practically everyone fears. Family, friends, sometimes even physicians listen to his lies and act as if they believed him. Their protection gives him freedom to continue his indulgence in alcohol—and keeps him from recognizing his problem. The alcoholic, being unreliable and untrustworthy, is a poor partner in any enterprise, including marriage. Due to accidents while drinking, alcoholics injure and kill thousands yearly; but more important, they daily injure and destroy the spirits of their associates.

Who is this alcoholic?

Is he a psychopath? Rarely—though psychopaths may drink abnormally.

Is he a homosexual? Occasionally—but most homosexuals do not drink excessively, and our psychological studies show that the majority of alcoholics are not homosexual.

By definition, an alcoholic is a person who is abnormally affected by alcohol, has come to depend upon it, and has attempted unsuccessfully to leave it alone. For the social drinker alcohol is an occasional pleasurable accompaniment to life; for the addict alcohol is a necessity which takes the place of life. In general most alcoholics were fundamentally normal people like ourselves who have acquired neurotic tendencies with severe disturbances of personality and serious emotional maladjustments. Most of them are psychoneurotics who utilize alcohol to obtain relief from discomfort, boredom, anxiety, frustrations, tension, or routine unhappiness.

Most psychoneurotics have weak emotional "roots." Their emotions are distinctly on the surface with no emotional depth. They fail to relate well to others. While they may experience many surface emotional squalls, they have little lasting sense of deep emotional deprivation. This characteristic is very noticeable in alcoholics. They have a lot of feeling, largely on the surface, with little or no depth. They are basically lonely people. No alcoholic or other psychoneurotic is cured until he learns to feel deeply—to love sincerely.

Alcoholism is a progressive disease. The individual indulges in moderate social drinking; then as the result of ignorance, carelessness, and inability to meet the to-be-expected failures and crises of

*Presented at the Kentucky State Medical Association Annual Meeting, Louisville, Kentucky, September 27-29, 1955

**Yale Center of Alcohol Studies.

***Medical Director, Silver Hill Foundation for the Treatment of the Psychoneuroses, New Canaan, Connecticut; Associate Clinical Professor of Psychiatry, Yale University School of Medicinne.

living, the individual becomes habituated to the anesthetic action of alcohol. Usually there is a consistent progression from social drinking to alcoholism. In youth one drinks socially to overcome self-consciousness, provide a sense of adventure, give false courage and anesthetize self-criticism; under conditions of emotional strain, it becomes an habituation which develops into alcoholism. One danger of alcoholism, like cancer, is late diagnosis. The first symptom is "careless drinking." The second is "drinking to feel better." To avoid the possibility of contracting this disease, it is a good rule to "never take a drink if you need it."

The Silver Hill group does not treat alcoholism per se but limits practice to the intensive study and treatment of the psychoneuroses. If the psychoneurotic patient is also alcoholic, treatment is not necessarily withheld. If the patient is psychoneurotic, is accessible to treatment, and seems to be a "good bet" from the alcoholic standpoint, we accept him. Consequently, this is a report on the re-educational method as applied in the treatment of a special group of patients.

Statistics

The report covers a period of over thirty years' experience gained in treating 20,000 psychoneurotic patients, 329 of whom drank abnormally. We have collected data on the results of treatment by seeing and corresponding with patients, their families, and their doctors. Five years or more have elapsed between treatment and evaluation. Members of our group and a research worker have studied these records, and we believe the statements made are accurate.

This particular study covers patients seen in a fourteen-year period. Out of a total of 185 alcoholics, 113 were successfully treated. These moderately severe alcoholics were a privileged, well-educated socio-economic group. Of the 113 patients, 62 per cent were men, 38 per cent women, most in the thirty to thirty-nine age bracket. They usually began drinking excessively between the ages of twenty and twenty-nine and had been drinking abnormally for approximately five years. Relatively few—20 per cent—of the successfully treated alcoholics had been drinking over ten years. Nearly all were married; one fourth of them had been divorced. A majority of the men held executive or professional positions; the women were homemakers. They had one-third as many children as do average American families.

The majority were emotionally immature individuals who had made poor social adjustments, unsuccessful marital adaptations, and had, in spite of superior intelligence and education, achieved only fair vocational success. Half of them were markedly aggressive, ego-centric, and selfish, with narrow interests. Some 35 per cent lacked initiative.

Their superficial conflicts did not often extend back into childhood, but resulted directly from alcoholism, their way of life, and present inter-personal relationships. Many alcoholics have a "dependent-independent" reaction—leaning on others, expecting to be protected, and at the same time asserting their "right" to do as they please. This, however, is also true of non-alcoholic psychoneurotics. It is more apparent in alcoholics whose inhibitions are removed, and who are in situations they cannot handle adequately.

Usually alcoholics are in social and financial difficulties before they are willing to accept treatment. While under the influence of alcohol they have behaved badly; they may be sexually involved, have spent money recklessly, endangered their positions, or lost their jobs. They have neglected their responsibilities and have in self-defense developed a projective process and blame everyone else, particularly their spouses. The female alcoholic is nearly always "considering" divorce, expects large alimony from her husband, and nearly always continues drinking if she separates from her husband.

Alcoholism seldom is the result of associating with undesirable persons or of going with a "fast" crowd. Most of the alcoholics included in these studies drank alone, and few had friends who were alcoholic. The psychopath who drinks is an exception to this rule, since psychopaths tend to associate with inferior people.

Causes

Although the causes of alcoholism are still largely undetermined, there were several precipitating factors apparently operative for both men and women; namely, physical illness, depression, anxiety, fear, loneliness, and prolonged insomnia. In women; dysmenorrhea, abortion, loss of a lover, marital incompatibility, extramarital affairs, death of a relative, or childbirth seemed to precipitate or continue excessive drinking. The "causes" advanced by men were generally excuses and rationalizations; in women excessive drinking often coincided with periods of definite strain.

Rationale of Treatment

The alcoholic is a maladjusted individual so poisoned by the drug that six or eight weeks are required to restore him to a state approximating physiological normality. His habits of living are so disorganized that he is usually below par physically; he is in trouble with his work and his family, and has lost his more desirable social relationships. He is projecting and blaming others, in addition to evading and rationalizing his difficulties. He has a protective amnesia as to the actual seriousness of his condition; he has long been fooling himself and believing that he is fooling others. He is a lost soul, without hope, and with no real confidence that he can recover.

The patient cannot be allowed to continue in this undisciplined way of life. He is out from under self-control and must accept firm medical directions. The kind, friendly physician is never soft nor overly sympathetic, and he never compromises with the necessities of treatment. When the patient threatens to discontinue treatment unless the doctor relents, the physician refuses to accept "Doctor Alcohol" as a medical consultant. The alcoholic who is bluffing nine tenths of the time, secretly hopes to find a doctor who has the strength that he himself lacks. To restore normal family, occupational, and social relationships, the physician will have to work with the family and key persons interested in the patient.

As a vital part of treatment, the alcoholic patient must reach and express three decisions:

To abstain from drinking forever

To continue treatment for at least three months

Not to take one drink while under treatment.

This agreement, willingly arrived at and rigidly adhered to, is the sine qua non of successful treatment.

Some alcoholics respond to office treatment—most do not. A few men can be successfully treated by the physician in his office while continuing work. This is seldom true of housewives. The "best bets" for office treatments are men who sincerely desire help, are doing important work which they like, and who show an unusual degree of emotional maturity and responsibility. Office treatment should be undertaken only when the patient agrees that if he drinks at all he will give up his work and accept resident treatment. Office patients must adhere strictly to a prescribed schedule of activities. The methods employed in office and resident treatment are essentially the same.

The ideal therapeutic milieu is a rehabilitation center where a comparatively small number of psychoneurotic patients are given intensive psychiatric-medical care. Since alcoholics have a bad influence on one another, there should be very few alcoholics in the group, and these preferably not known to one another as alcoholics.

Method of Treatment

The following principles for treatment of the alcoholic have evolved as the result of the experiences of the Silver Hill group. We are convinced that this is a valuable method of treatment, and if it does not work, we believe nothing will. The success of its application depends on the strength of personality and character of the doctor, as well as his skill in employing these methods:

Treatment is divided into the following phases:

Attention to preliminary necessities

Carrying out didactic re-educational procedures

Application of insight into alcoholic personality and maneuvers

Re-training of addictive alcoholic impulses

Fitting into home, work, and society

Intensive, prolonged follow-up.

A therapeutic history is taken by a physician who understands alcoholic and neurotic mechanisms and knows how to deal with them. The first few minutes of contact between doctor and patient may determine the success of treatment. A neurotic tries to pull the wool over the doctor's eyes, and it is detrimental to treatment for him to think he has succeeded. A therapeutic history reveals to the patient many things he usually does not want to see. As the doctor takes the history, the patient perceives that he has been living unwisely; that his personality development and point of view are grossly distorted. He is forced to see that for a longer time than he has previously been willing to admit, he has drunk excessively, lived an abnormal, alcoholic way of life, and employed psychoneurotic evasions of responsibility.

A thorough physical examination is an important part of treatment. The alcoholic patient seldom has any outstanding or-

ganic findings, but he is usually very soft, gets insufficient exercise, and sometimes is disgustingly fat. Since obesity is due to self indulgence and lack of control, these patients, if obese, must lose weight as a part of treatment for alcoholism. If a fat alcoholic will not lose weight, he will seldom stop drinking. It is useless to tell an organically ill alcoholic that he will die if he does not stop drinking!

After the therapeutic history is taken and his physical condition appraised, the patient is placed on a schedule of work, rest, exercise, and play. Being self-willed, he often rebels at this and threatens to discontinue treatment. He must discover at once that such tyrannical methods will no longer work; now he is in the hands of a doctor who does not scare!

The alcoholic patients who say they drink because they are self-conscious and ill at ease with people must be socialized and taught to be comfortable with competitive associates (not other alcoholics). There must be no fraternizing with the "second raters" who habitually cut corners. Nightclubs, jazz jamborees and all "hot spots" are forever out of bounds. Alcohol is the quickest and most complete reversal of civilization to animalization—therefore alcoholics must renounce all places where animalism is encouraged or tolerated.

When these preliminary necessities are firmly attended to, the patient is ready for intensive, objective psychological re-education. This process takes approximately six weeks, during which time all discussion of alcoholism, personal and situational problems is held strictly in abeyance. Daily hour-long interviews cover the didactic re-education. Through study, discussion, and practice the alcoholic is taught the principles and techniques of good personal mental hygiene. The nature of adaptation, the unreliability of primitive emotions, together with the need to find acceptable outlets for emotional demands, are discussed in detail.

The alcoholic, and indeed many psychoneurotics, are like the school boy who diverts the teacher's attention from the lesson he is not prepared to discuss by feigning interest in extraneous subjects. Useless repetition becomes truly the patient's "story," strengthening the rationalizations through which he has been deceiving himself and attempting to convince others that he is not an alcoholic. Through ventilation he is afforded opportunity to face facts, to discuss freely with an objective physician the underlying factors in his alcoholic addiction and what he can do to get well. Re-education stresses the necessity of using intelligence and the need for some idealistic concept of life. Escape, defense, projection and rationalization are explained in detail, with personally applicable examples. The hedonistic philosophy of seeking pleasure and avoiding pain is demonstrated as being completely untenable.

Patients are shown the required techniques of everyday adjustment, taught to make clear-cut decisions, and helped to attain personal efficiency. They learn that an ideal of unself-seeking service brings man his only comforting rewards.

Later, insight into the nature of alcoholism is provided by a four weeks' reading period, a discussion of the nature of alcoholism, and the psychological mechanisms of the addict. By this time the alcoholic is fully cooperative—he may even be too abject. He is like a convert at a revival meeting; he wants to enumerate more and better sins. Therapeutically these confessions mean nothing, and he should be told so. When he no longer attempts to justify his impossible conduct, he begins to welcome the opportunity of understanding the routine alcoholic reactions and of studying the method other alcoholics have found useful in continuing abstinent. During this direct alcoholic education the patient must forever renounce alcohol and grant that he can never "drink like a gentleman." Alcoholic addicts maintain a secret comforting thought that some day they may be able to take a drink. This universal alcoholic myth must be repeatedly and forcefully demolished. The alcoholic may be bored with repetitiousness. Let him be! He must learn to endure boredom.

In the fourth period of treatment we retrain the subconscious mind of the patient through the daily use of "Alcoholic Leaflets." These the patient studies, summarizes, and discusses in each daily interview, then applies them to his life. The leaflets serve a two-fold purpose; first, after six weeks of treatment with total abstinence, most alcoholics believe they are well. The are not—the danger of falling into old habits is great, since alcoholism is a true addiction. An alcoholic's subconscious constantly directs him toward alcohol and will continue to do this for years, perhaps forever. In his subconscious mind a thousand "evil spirits" may tempt him by saying: "Alcohol will keep you from having a coronary thrombosis." "In

this cold weather a drink will ward off pneumonia." "Just sit at a table in the bar and enjoy the light and warmth among friends." "A little brandy in hard sauce will do you no harm." "One way to get even is to get drunk." Thus the subtle devils ensnare him—unless he is immunized. Second, when preceded by re-education and the adoption of good physical habits of living together with alcoholic insight, the "Alcoholic Leaflets" are effective in reducing habitual alcoholic rationalizing.

The convalescent alcoholic needs a supportive milieu in his home and on his job, and this the doctor must work with his associates to ensure. At the end of ten weeks of treatment, the patient should be sent home a few times for twenty-four to forty-eight hours, and on one of these trips he should re-establish contact with his office.

He is finally medically discharged with a written home schedule which the doctor expects to see that he follows. He must no longer associate with people for whom alcohol is a way of life. Cocktail parties are not prohibited, but he will say frankly that he cannot drink because he is an alcoholic. He will not boast about this, since no one is interested, but he is personally proud that he has conquered his problem. He does not feel superior to, nor envious of, friends who drink in moderation; he merely believes in his own non-alcoholic way of life.

The family must trust the alcoholic. There must be no questioning of conduct or motives, no nagging and no upbraiding for past misconduct. If they suspect he is drinking, they should not discuss this with the patient, but communicate at once with the physician. Their part is to love, support and encourage; to make him know that he is important to them!

For a period of years the alcoholic patient must keep in close contact with the doctor, a friend upon whose integrity he relies. The first three months the patient should be seen every two weeks; the next six months, usually once a month will suffice; then at six-month intervals for three years. (In this recommendation, once again, alcoholism is compared to other malignancies.) The follow-up interviews are not limited to ascertaining whether or not the patient is drinking; it is taken for granted he is not, since prior to discharge he agreed that the first time he takes a drink he will immediately inform his doctor. The follow-up interviews are devoted to a general mental hygiene review, together with a therapeutic evaluation of his continuing personality development. Just as people have a physical checkup, they need to see a psychiatrist for an emotional health checkup. This is certainly true of all alcoholics.

Results

Records available for the past twenty years show an incidence of 7.5% alcoholics among 4300 psychoneurotic patients. Of 185 patients (122 men and 63 women) treatment was successful in 113 cases, or for 61% of the alcoholics. This represents 67% of the men treated for alcoholism and 33% of the women. Married women have a higher rate of success—about 80% remain abstinent. Most of the women included in this study were single.

Of the successfully treated alcoholics 68% were under treatment once; 18% twice; 14% three times. Best results were obtained with patients in the age group from thirty through thirty-nine who had been drinking not more than five years and were continuously in residence three months or longer.

Conclusions

On the basis of statistical data available for the past twenty years and experience gained in the treatment of 329 alcoholics among 4300 psychoneurotic patients, the following conclusions seem justified:

Alcoholism is a malignant, progressive, addictive disease, showing a tendency to be familial.

This disease develops progressively, beginning with social, moderate drinking in fundamentally normal persons of good intelligence and high ideals who, but for this addiction, might be outstanding citizens in their communities.

No clinical syndrome is demonstrable, but certain characteristics are frequently seen. Alcoholic patients are emotionally immature individuals who (in spite of adequate intelligence and education) because of neurotic tendencies have made an unsuccessful adjustment to life. They have resorted to alcohol in an attempt to find satisfaction which this addiction never brings.

There are certain criteria which indicate whether alcoholic patients are accessible to and will profit from the re-educational method of treatment. These are:

The necessity of becoming abstinent; i.e., loss of position or threat of divorce.

An unequivocal self-made decision to

undergo treatment for a minimum of three months.

Agreement to accept and live up to a prescribed regime during treatment and upon return to home and work.

Full cooperation with the physician throughout, including the vitally important follow-up period.

The "best bets" are patients with ego strength who have shown ability to withstand strain, are willing to accept pain incident to a useful life, and who have sufficient incentives to compensate for the permanent renunciation of alcohol.

After treatment we base favorable prognosis on the following criteria:

Sincerity and cooperation during treatment.

Good rapport with the doctor in what has now become a relationship of mutual confidence and trust.

The patient's conviction that as an alcoholic he can never drink.

Good social adjustment.

A return to satisfying work.

The existence of understanding and cooperation from his family.

The acquisition of a practical ideal of unself-seeking service to others.

Strong, wholesome family ties and a stable working life are conducive to recovery. While the patient never gives up alcohol for the sake of another, love and the enjoyment of a happy family life help immeasurably.

Treatment, whether in office or in residence, must not stop short of a completely reorganized non-alcoholic way of life. In many instances the family doctor and internist can successfully treat alcoholism—provided they have the courage to face the facts with the patient, and devote the thought, skill, and time which are necessary to long-term treatment.

The ideal milieu is a re-education center, with only a limited number of alcoholics among the other patients. In such a favorable environment the majority of alcoholics who have undergone this method of re-education have recovered.

In closing, alcoholism is a malignant disease—malignant to the individual and to society. Unlike most malignant growths, alcohol destroys not only the body but the spirit of its victims. Medicine cannot ignore professional and social responsibility for fearlessly diagnosing and treating this disease which renders millions unfit for family and community life.

CASE DISCUSSIONS

FROM THE UNIVERSITY OF LOUISVILLE HOSPITALS

ABDOMINAL PREGNANCY

Patient Protocol

R.N.N.*, a 37 year old gravida 2 para 1, was admitted to Louisville General Hospital on November 25, 1955, complaining of a painful localized swelling about the umbilicus of several weeks' duration, and of gradual increase in size of the abdomen for about five months. The patient had been treated on several previous occasions in the gynecologic out-clinic for episodes of pelvic inflammatory disease. Her last menstrual period had begun on January 23, 1955, and had lasted five days. There was no subsequent vaginal bleeding until November 3, except for minimal spotting of one day's duration on two occasions, in February and in March. She complained of irregular cramping pains in the abdomen on several occasions since January, and specific, more severe, episodes had occurred in February, March, and May. The bleeding which had started on November 3 had been quite profuse, and continued until the time of admission.

Physical Examination

The patient was a well-developed negro woman in no acute distress. The blood pressure was 108/64, pulse 76, temperature 100.2°. General physical examination was within normal limits except for the abdomen and pelvis. On palpation of the abdomen, there was noted a moderately tender, relatively symmetrical, ovoid mass which extended to 20 centimeters above the symphysis pubis. No fetal heart sounds were heard. On vaginal examination, there was found a slight relaxation with first degree cystocele and rectocele. The cervix was clean and displaced toward the symphysis. It was difficult to palpate the uterus, but there was a rubbery mass which filled the cul de sac and indented the rectum, and, within this sac, irregular spicular bony structures were felt; these were thought to be fetal bones.

Laboratory Findings

The hemoglobin was 12.2 grams. Urinalysis was negative. The white blood count was 6,300 with normal differential. A plain film of the abdomen showed a fetus of approximately six months' gestation in oblique presentation with the head overriding the left iliac fossa and the small parts in the pelvis. There was overriding of the fetal skull bones. A hysterosalpingogram performed with Salpix showed the uterine cavity to be displaced slightly toward the right, and to be regular in shape. (Fig. 1). The right fallopian tube was easily visualized, but the Salpix did not flow into the left fallopian tube. The fetal parts could be seen on the hysterosalpingogram lying outside the uterus.

Operation

On November 26, laparotomy was performed. The uterus was enlarged to the



Figure I

Hysterosalpingogram using water soluble radiopaque medium. Symmetrical uterine cavity. Fetus with Spalding's sign in breech presentation free in peritoneal cavity.

*Hospital No. 234509.

size of a three months' pregnancy, and was the site of a pedunculated myoma measuring approximately six centimeters in diameter which was attached to the fundus. A small intramural myoma measuring approximately three centimeters in diameter was present in the anterior wall of the uterus. The placenta was found to lie to the left of the uterus and superior to it; it was adherent to portions of the omentum, to the left superior and posterior surface of the uterus, and to the left broad ligament and tube. The uterus was slightly displaced, and exploration posterior to it, disclosed a fetus in its amniotic sac. The latter was opened, and the extensively macerated fetus was freed from the surrounding sac and extracted without difficulty. Exploration after removal of the fetus showed that vessels in the omentum were not greatly engorged; since the most proximal portion was involved and intestinal involvement was minimal, it was decided that removal of the placenta was technically feasible without risk to the patient. After removal of the placenta, abdominal hysterectomy and left salpingo-oophorectomy were performed without difficulty. At no time was there any alarming hemorrhage, and the patient remained in good condition throughout the procedure. She made an uneventful postoperative recovery.

Discussion

DOUGLAS M. HAYNES, M. D.

Department of Obstetrics and Gynecology

Abdominal pregnancy is a sufficiently rare entity that clinically observed examples of it deserve to be reported. The diagnosis is often difficult, as the condition characteristically mimics other more common conditions. The following diagnostic features should suggest the possibility of an abdominal pregnancy: (1) History of acute, painful abdominal episode at a time in early pregnancy, in keeping with tubal rupture or abortion. (2) History of repeated episodes of acute abdominal pain with fever and peritoneal irritation occurring in a patient with signs of advancing pregnancy. (3) Unusually easily palpable fetal parts. (4) Abnormal presentation and position. (5) Episode of pseudolabor near the expected date of delivery. Roentgenologic signs of abdominal pregnancy include absence of a definite uterine shadow; high location of the fetus in the abdomen; and visualization of fetal parts just beneath the abdominal wall in lateral views of the abdomen. It should be noted that hysterosalpingography is rarely indicated in these patients, as it may damage an intrauterine pregnancy when such is present, and might also result in the entrance of air or radiopaque medium into maternal sinusoids, producing possible embolic phenomena. In this patient the procedure was performed with a water-soluble rather than an oily medium so that the risk of embolism was lessened; and the positive roentgen evidence of fetal death obviously eliminated the danger of interrupting an intrauterine gestation. In view of these facts, the risks of hysterosalpingography were taken in the interest of establishing an accurate preoperative diagnosis.

Treatment

The problem of treatment of abdominal pregnancy involves the answers to the following questions: What is the best time for operation? What should be done with the placenta? There is general agreement that, when the diagnosis is made early in pregnancy, immediate operation is indicated; and most writers believe that this principle should be followed without regard to the period of gestation. A minority has suggested that there may be some place for expectant treatment in an attempt to secure a viable infant when the diagnosis is first made shortly before viability has been reached, provided there is no maternal indication for prompt intervention. This combination of circumstances is rarely encountered clinically; and the best rule to follow is that calling for prompt intervention as soon as diagnosis is made.

Since the placenta may be implanted on any of the intraperitoneal viscera, and since uncontrollable hemorrhage often occurs when its removal is attempted, most authorities recommend that the umbilical cord be ligated as close to the fetal surface as possible, and that the placenta be left in situ. Although resorption may be complicated by the development of fistulae, peritonitis, or mechanical intestinal obstruction, these can be dealt with more satisfactorily than can massive and uncontrollable hemorrhage. The patient reported here illustrates a circumstance in which removal of the placenta is sometimes indicated; namely, when the fetus has been dead long enough for placental vascularity to be greatly reduced, especially if implantation does not involve bowel surfaces. The surgeon must decide at the operating table which course of action will best serve the patient's interests.

SPECIAL ARTICLES

THE PEOPLE AND RURAL HEALTH

How much does the Kentucky rural health council movement mean to the thinking people in the rural areas of our state?

Perhaps the recent 1956 Rural Health Conference in Louisville provides an easily understood answer. Because the experience with that conference contained such important negative elements, it is perhaps permissible to say that the results produced by it may properly afford a rock-bottom evaluation of this movement which was instituted as a public service by the KSMA in 1951.

First, let us look at the negative aspects of the conference. They sprang principally from the weather, which could hardly have been worse.

The conference was held January 19. On January 18, a heavy snow began which continued through the night and part of the day of the meeting itself. Roads all over the state were impassable. Airplanes were not landing in Louisville.

Because of these transportation difficulties, the conference program was virtually decimated at the outset. Gant Gaither, M.D., of Hopkinsville who, as president of the KSMA, was scheduled to deliver the opening address of the conference arrived two hours after the conference was scheduled to begin. Other speakers within the state who had not come the night before were also delayed in arrival.

The Henry County Homemakers Chorus, which was scheduled to provide entertainment at the luncheon, reported their members found it impossible to get to New Castle from their farm homes.

The principal attraction at the luncheon was to have been an address by Leonard E. Read, president of the Foundation for Economic Education, who planned to fly from Chicago the morning of January 19. Cancellation of flights into Louisville made it impossible for him to appear.

From the foregoing it may readily be seen that the persons responsible for the conference could be forgiven for assuming that an attendance of 20 or 25 persons from rural Kentucky would be reasonable.

It must be borne in mind that the Kentucky Rural Health Conference like the whole Kentucky rural health council movement which they aim to promote, are strictly voluntary meetings. There are no elected delegates who have a special sense of responsibility to attend. Only those who really want to come, come. With the weather conditions that prevailed, even the most enthusiastic would have been excused for not coming.

In this light, your KSMA Rural Health Committee and the representatives from other state-wide organizations which sponsor the annual conference feel that the actual registration of 149 people at the conference is a tremendous endorsement by the people approving the service which the conference provides. It is more than that. It is substantial evidence that the people want to assume their proper obligations for good health in those areas of activity where they are qualified.

Thirty Kentucky counties were represented. This meant that many of the representatives were able to attend only after overcoming substantial travel obstacles.

So there was a good attendance at the conference. Equally important is whether the conference program was really worthwhile. Did these people who had braved the elements feel that their effort was well spent? Or did the changes in the conference program, leave them with a completely let down feeling? In the opinion of those responsible for the conference, it was here that the power of the whole movement was demonstrated. It was here that the conference showed the virility of the idea that people who want to accomplish something through voluntary means can do it if it seems important to them.

The program, after a slight delay, was begun with the scheduled panel discussion on "Your Heart." Participants on the panel were Ralph Denham, M.D., Louisville; Carl Fortune, M.D., Lexington; Murray Kinsman, M.D., Louisville; and Frank Moore, M.D., Bowling Green. Frank Duncan, M.D., Monticello, served as moderator.

Everyone who heard this panel felt that

it was outstanding—informative, interesting and practical.

The panel was followed by a symposium in which the subject "Using Our Present Medical Care and Health Resources" was discussed. Garnett Sweeney, M.D., Liberty, spoke as a physician; Mrs. James T. Brookshire, Hardinsburg, as a homemaker and Miss Catherine Knarr, Falmouth, as a home demonstration agent. J. E. Stanford, St. Matthews, of the Kentucky Farm Bureau Federation, substituted ably on short notice for Holmes Ellis, Murray, who had been scheduled to speak as a farmer. Spalding Green, D.D.S., Lebanon, was moderator for the symposium and the buzz session in which the panel participated during the afternoon.

Special mention should be made of the youth movement in the panel. Jerry Ringo, Rothwell, recent winner of the American Farm Bureau's national talk meet, represented the FFA. Elizabeth Ann Moore, Augusta, who plans to study medicine, represented 4-H. It was the consensus that these two youngsters, both students at UK, stole the show.

When the conference reached the luncheon period there was a problem. This was most ably solved through the good offices of Dr. Gaither who had been by-passed in the morning. With his usual eloquence, he stepped into the breach and delivered a splendid luncheon address.

The most important part of the conference as originally planned, however, were the individual discussion groups during and after lunch which addressed themselves to the topic "Using Our Present Medical Care and Health Resources" and the buzz session on the same subject during the afternoon. During the buzz session questions prepared by the small groups

(Continued on page 277)



These physicians discussed "Your Heart" at the 1956 Rural Health Conference January 19. Frank Duncan, M.D., Monticello, center, acted as moderator. From left to right, the panelists are: Ralph Denham, M.D., Louisville; Carl Fortune, M.D., Lexington; Dr. Duncan; Frank Moore, M.D., Bowling Green; and Murray Kinsman, M.D., Dean of the University of Louisville Medical School.

EDITORIALS

OBSTETRICS IN RURAL PRACTICE

One of the biggest recent changes in medicine is taking place in the practice of rural obstetrics. The advent of the clinic and small rural hospital is revolutionizing this practice.

Formerly, and this is still true in many areas in Kentucky, obstetrics was the most neglected and backward phase of rural medicine. Pregnancies were handled much like this. The husband would drop by and inform the physician that his wife was expecting in a few weeks or months and ask him to accept the case. No more would be heard from the patient until the physician was summoned during her labor.

The patient was delivered at home under poor conditions at best, with inadequate lighting, no asepsis, awkward delivery position, little or no anesthesia, and little or no assistance. Since there was no prenatal care, the physician had no warning of what complications he might expect. Toxemias, twins, disproportions, anemia, etc., had to be handled on the spot without benefit of preknowledge or preparation.

The numerous obstacles to surmount in attempting a sterile delivery soon led most physicians to abandon any attempt at technique, and to carry with him only two clamps and a pair of scissors, plus a mask for chloroform and a pair of forceps to handle difficult cases. There was often another labor case waiting some miles away, and an office full of patients waiting back in town. It was frequently necessary to resort to pitocin to terminate the case as soon as possible. Most repairs were done simply by putting the patient's legs together and leaving the rest to nature.

One often hears the statement, "They got along all right." This is not true. The difference in incidence of postpartum infection, speed of recovery and every phase of fetal and maternal morbidity and mortality is appalling. The higher incidence of hypertension, chronic nephritis, cystocele, rectocele, rectal incontinence, anemia, chronic cervicitis, etc., bears stark testimony to the fallacy of the above statement.

The rural clinic simply combines labor and delivery room, x-ray and laboratory with the physician's office. The small autoclave supplies sterile material, the nurse and aides, the important assistance. The physician can carry on office hours while the patient is in labor, and observe her during the immediate postpartum period. He is able to perform a sterile delivery with adequate anesthesia. Good facilities alone encourage better obstetrics. Gone is the need for rushing the labor.

Rural patients appreciate prenatal care and better delivery just as much as do their cousins in the urban population, and education of the patients toward clinic delivery is easier and much faster than one would anticipate. Patients want to be examined at regular intervals during gestation; they want to be shaved at the time of delivery; they appreciate being watched during labor and receiving adequate anesthesia. Two or three years after the establishment of a clinic in a rural area, the patients expect and demand the better obstetrics it affords.

Great strides are being made in rural obstetrics. It has become the duty and responsibility of the country physician to bring good obstetrics to his patients.

R. Burke Casper, M. D.

Opinions expressed in contributions to this Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

FACTORS IN MEDICAL CARE

The physician and dentist may well congratulate themselves that in the increasing costs of medical care they have not demanded a lion's portion. In a pamphlet depicting in charts the economic position of medical care from 1929 to 1953, the Bureau of Medical Economic Research of The American Medical Association has presented some findings worthy of our study. In 1930, four percent of the average man's income was spent for medical care. In 1953, 4.4 percent of the average income was spent for medical care and this increase has been gradual over this period of time—the factor in the increase being the great growth of voluntary health insurance.

The percentage increase for total medical care has not represented an increase of profit to the physicians and dentists. In 1930, 1.3 percent of the average income was paid to physicians and dentists. In 1953, 1.2 percent was paid for the same service. The great item of increase has been in the cost of hospital care which has gone up from .6 of one percent in 1930 to 1.1 percent in 1953. Moreover, the average American spends a larger percentage of his income for recreation than he does for medical care, and certainly it should be so.

The percentage of incomes spent for physicians' and dentists' services, and even for drugs, is shown to have gradually declined over the years under discussion, whereas, the percentage spent for hospital care and for other health items, including health insurance, has increased substantially. The increase in percentage for hospital care has increased most rapidly of all.

Of the dollar spent for medical care in 1929, the physician received 33 cents and the dentist 16 cents. The same dollar spent in 1953, the physician received 28 cents and the dentist 10 cents. It is interesting and rather surprising that of the medical dollar in 1929, 20 cents was spent for drugs, whereas, in 1953 the drugs cost only 16 cents—in spite of the tremendous increase in the price of the various antibiotics during the past few years. As would be expected of the medical-care dollar spent in 1929, 14 cents went to hospitals and of the same dollar spent in 1953, 26 cents went to hospitals. Projecting that to 1956, it appears that the amount has just about doubled in that period of time.

Physicians' and dentists' fees have not risen as rapidly as have the prices of all goods and services bought by the consumer. The index for physicians' fees was 161 in 1954 as compared with 1940. There is a general consumers' price index which stands at 192 and the total cost of medical care and drugs at 172. Hospital rates meantime have brought this index to the surprisingly high level of 324.

During the same period under discussion, percentage increase in the average income of physicians has been less than that of the population generally. From 1929 to 1949, the percentage increase in general was 109% but that of the physician is 108%. From 1949 to 1951, the general increase in income was 15%, whereas, the increase in the income of the physician was 13%.

These statistics do not tell an unexpected or surprising story. In view, however, of the bitter criticism directed toward the medical and dental profession during the past two decades we are happy to learn that economically we are on the safe side, and certainly with these facts in mind one cannot successfully claim that we have exploited the medical care of the American people to our own individual profit.

SAM A. OVERSTREET, M. D.

ORGANIZATION SECTION

AMA President to Speak April 16 at Senior Day Program

Elmer Hess, M. D., Erie, Pennsylvania, President of the American Medical Association, will be the guest speaker at the 1956 Senior Day program April 16. The program is sponsored by the KSMA in cooperation with the Jefferson County Medical Society and the University of Louisville Medical School.



Dr. Hess

"The Senior Day program is an excellent opportunity for our senior students to get a look at the other side of medicine, the sometimes neglected side. Here at the medical school, we supply an outstanding, but crowded medical curriculum. The Senior Day program is devised to bridge the gap between academic medicine and applied medicine," said J. Murray Kinsman, M. D., Dean of the University of Louisville Medical School.

The morning session will be held in the Rankin Amphitheatre at the Louisville General Hospital with Gant Gaither, M. D., Hopkinsville, KSMA President, as the speaker.

The afternoon session, beginning at 2:30 p.m., will be held in parlors B and C of the Kentucky Hotel. Richard G. Elliott, M. D., Lexington, Chairman of the KSMA Senior Day Committee, is to preside at this session.

The program will include the following features:

A discussion, "Bridging the Gap" by Oscar Hayes, M. D., Louisville.

A panel discussion, "Where and What You Practice," H. Burl Mack, M. D., Peewee Valley, moderator; George Brockman, M. D., Greenville; Ralph Lynn, M. D., Elkton, and Robert Robinson, M. D., Paducah, will be panel members.

A talk, "The Mechanics of Setting Up a Practice."

A panel discussion, "Human Equation in Medical Practice," John Floyd, M. D., Lexington, moderator. Russell H. Davis, M. D., Pikeville; Glenn Bryant, M. D., Louisville; Homer B. Martin, M. D., Louisville; and Vinson Pierce, M. D., Covington, will be panel members.

A discussion, "Matter of Money," Robert Long, M. D., Louisville, and

A talk, "When You Think of Yourself."

A social hour is planned at 6 p.m. in the Terrace Room followed by a dinner at 7 p.m.

The evening session, at which Dr. Hess will speak, will be held jointly with the Jefferson County Medical Society. Irvin Abell, Jr., M. D., President of the JCMS, will preside. Senior students will be individual guests of the members of the JCMS at the dinner.

The Woman's Auxiliary to the KSMA will entertain the wives and sweethearts of the senior students at a tea at 2:30 p.m.. at the Kentucky Hotel. Wyatt Norvell, M. D., New Castle, will be the guest speaker at the tea.

Russell E. Teague, M. D., Named Ky. Health Commissioner

Russell E. Teague, M. D., was sworn in as Commissioner of Health, February 16, 1956. He succeeds Bruce Underwood, M. D., who resigned to take a position with the Public Health Service in Washington, D. C.

"We are most happy to welcome Dr. Teague back to Kentucky and we of the Kentucky



Dr. Teague

State Medical Association are looking forward to working with him," said Gant Gaither, M. D., Hopkinsville, KSMA President.

A native of Hopkins County, Dr. Teague was graduated from the University of Louisville School of Medicine. He interned at Louisville General Hospital and received a Master of Public Health Degree from Johns Hopkins University in Baltimore.

Dr. Teague was engaged in public health work in Kentucky from 1931 to 1945. In 1945 he joined the Public Health Service. Dr. Teague was Medical Director of the Bureau of State Services in the United States Public Health Service from 1955 to the time he became Kentucky commissioner.

In 1954 Dr. Teague received the Award of Merit from the Pennsylvania Public Health Association. He was certified by the American Board of Preventive Medicine and Public Health in 1948.

A member of the Presbyterian Church, Dr. Teague is a Rotarian. He is a veteran of World War II.

Dr. Underwood Praised for Work in KSMA and Health Dept.

The Kentucky State Medical Association sponsored a Testimonial Dinner in honor of Bruce Underwood, M. D., January 19, at the Kentucky Hotel in Louisville. Approximately 180 persons attended the affair.

Representatives from the KSMA, Health Department, and the Rural Kentucky Medical Scholarship Fund and the Medical Research Commission praised Dr. Underwood for his work. His resignation as Secretary and General Manager of the KSMA and Commissioner of Health in Kentucky became effective on February 1.

E. M. Howard, M. D., Harlan, President of the State Board of Health, said that progress is the theme in talking about public health service and under Dr. Underwood's supervision progress has continued and increased. He said when Dr. Underwood became commissioner of health $600,000 was appropriated for state and county health departments. The figure today is about $2,000,000.

"What he's done has been the best for the greatest number of people," said C. C. Howard, M. D., Glasgow, Chairman of the Rural Kentucky Medical Scholarship Fund and the Medical Research Commission. Dr. Howard closed by saying simply, "Bruce, we appreciate you and we'll miss you."

Gant Gaither, M. D., Hopkinsville, KSMA President, said Dr. Underwood had "lifted the KSMA out of the morass of mediocrity and patterned it after the AMA."

"We have not always been as thoughtful of Bruce Underwood as he has been of us," Dr. Gaither continued, "I have seen him treated rudely and I've seen him take it like a Christian gentleman."

"We appreciate him as a doctor who knows there's a greater power upstairs and doesn't mind admitting it," said Wyatt Norvell, M. D., New Castle. Dr. Norvell, as chairman of the Committee for the Bruce Underwood Testimonial Dinner, presided over the dinner.

Delmas Clardy, M. D., Hopkinsville, Vice Chairman of the KSMA Council, presented Dr. Underwood a silver service, a "going away" gift from the Assocation. Dr. Clardy made the presentation for J. Vernon Pace, M. D., Paducah, Chairman of the Council, who was unable to attend the dinner because of bad weather conditions.

After the presentation Dr. Underwood thanked his co-workers in the KSMA and Health Department and his family for their help and cooperation during the past years.

Dr. William Pettigrew, Pastor of the Walnut Street Baptist Church, Dr. Underwood's Church, gave the invocation and the benediction.



Delmas Clardy, M.D., Hopkinsville, Vice-chairman of the Council, presents a silver service to Bruce Underwood, M.D., at the January 19 Testimonial Dinner in his honor. The service was a "going away" gift from the KSMA.

General Practice Academy Plans Annual Meeting, April 18-20

Jack S. DeTar, M. D., Milan, Michigan, president of the American Academy of General Practice, will be a featured speaker at the 1956 scientific session of the Kentucky Chapter of the American Academy of General Practice April 18-20 at the Brown Hotel in Louisville.

All KSMA members are cordially invited to attend the scientific meetings, H. Burl Mack, M. D., president of the Kentucky Chapter, who made the announcement, said.



Dr. Cole

Seven KSMA members and one Kentucky oral surgeon will present papers during the meeting, according to Carroll Witten, M.D., Louisville, chairman of the program committee.

Julian Cole, M.D. Henderson, president elect of the Kentucky Chapter, will be installed as president during the meeting.

Six nationally known out-of-state physicians will speak during the meeting. They are: Frank Mayfield, M. D., Cincinnati; Oscar Hampton, M. D., St. Louis, Missouri; Jerome Weiss, M. D., New York; Dr. De Tar; Richmond Smith, M. D., Detroit; and A. Lee Lichtman, M. D., New York. The executive secretary of the AAGP, Mac Cahal, Kansas City, Missouri, will be guest speaker at the annual banquet, April 18.

The complete program for the meeting follows.

PROGRAM

KENTUCKY CHAPTER OF AMERICAN ACADEMY OF GENERAL PRACTICE

Brown Hotel, Louisville — April 18-20, 1956

April 18

H. Burl Mack, M. D., presiding

9:20 a.m. **Invocation**

9:25 a.m. **Welcome**
E. H. Kremer, M. D.,
President, Jefferson County Chapter

9:30 a.m. **Welcome**
H. Burl Mack, M. D.,
President, Kentucky Chapter, AAGP

9:35 a.m. **Remarks**
Gant Gaither, M. D.,
President, KSMA

9:45 a.m. **"Oral Lesions"**
James E. Skaggs, Jr., D. M. D.,
Louisville

10:15 a.m. **"Practical Points in Plastic Surgery"**
Thomas Giannini, M. D.,
Louisville

10:45 a.m. **"Neurologic Injuries"**
Frank Mayfield, M. D.,
Cincinnati, Ohio

11:15 a.m. **Recess—Visit Exhibits**

12:00 **Luncheon and Business Meeting**

12:00 **Ladies Luncheon and Style Show**

2:30 p.m. **"Speed Injuries"**
Homer B. Martin, M. D.,
Louisville

3:00 p.m. **"Mass Casualties"**
Oscar Hampton, M. D.,
St. Louis, Missouri

3:30 p.m. **Recess—Visit Exhibits**

4:00 p.m. **Round Table on "Trauma"**
R. Arnold Griswold, M. D.,
Moderator
Thomas Giannini, M. D.
Oscar Hampton, M. D.
Homer B. Martin, M. D.
Frank Mayfield, M. D.
James Skaggs, D. M. D.

6:30 p.m. **Annual Banquet**
Mac Cahal, Kansas City, Mo.,
Executive Secretary, AAGP,
speaker; followed by Dance and Entertainment

April 19

Julian Cole, M. D., Henderson, President-elect, Kentucky Chapter, presiding

9:00 a.m. **"Bleeding as a Complication of Pregnancy"**
Edwin P. Solomon, M. D.,
Louisville

9:30 a.m. **"Dystocia as a Complication of Pregnancy"**
Robert F. Monroe, M. D.,
Louisville

10:00 a.m. **A Manikin Demonstration Lecture Covering the Common Obstetrical Maneuvers and the Use of Forceps**
Douglas M. Haynes, M. D.,
Louisville

10:30 a.m. **Recess—Visit Exhibits**

11:00 a.m. **Round Table Panel on "Prolonged Labor"**
Julian B. Cole, M. D., Moderator
Douglas M. Haynes, M. D.
Robert F. Monroe, M. D.
Edwin P. Solomon, M. D.

12:00 **Luncheon and Business Meeting**

2:00 p.m. **"Management of the Peptic Ulcer"**
Surgical—Howard E. Dorton, M. D., Lexington
Medical—Frank Moosnick, M. D., Lexington

2:30 p.m. **"The Diarrheal Syndrome"**
Jerome Weiss, M. D.,
New York, New York

3:00 p.m. **"The Digestive Tract in Roentgenology"**
Robert Akers, M. D.,
Louisville

3:30 p.m. **Recess—Visit Exhibits**

4:00 p.m. **Round Table Panel on "Gastrointestinal Diagnosis"**
Walter S. Coe, M. D., Moderator
Robert Akers, M. D.
Howard E. Dorton, M. D.
Franklin B. Moosnick, M. D.,
Jerome Weiss, M. D.

6:30 p.m. **Stag Banquet**
Jack S. DeTar, M. D.,
Milan, Michigan,
President, AAGP, Speaker

April 20

9:00 a.m. **"Insipient Digitalis Intoxication"**
Ralph Denham, M. D.,
Louisville

9:30 a.m. **"Practical Endocrinology"**
Richmond Smith, M. D.,
Detroit, Michigan

10:30 a.m. **"Athletic Injuries"**
A. Lee Lichtman, M. D.,
New York, New York

11:00 a.m. **Recess—Visit Exhibits**

12:00 **Adjournment**

Council Sets Deadline—April 1 for Paying KSMA Dues

The Council of the Kentucky State Medical Association has set April 1 as the deadline for paying 1956 annual KSMA dues.

Gant Gaither, M. D., Hopkinsville, KSMA President, has asked that all physicians who have not yet done so, send their County, KSMA, and AMA dues to the secretary of their county society.

Dr. Gaither listed the benefits that would be lost by failing to pay dues. Some were: Cancellation of the subscription of the KSMA Journal, withdrawal of support to organized medicine and the many public service projects it sponsors, and jeopardization of the right to continue carrying certain needed insurance and other privileges that go with membership in the KSMA.

Kentucky Surgeons to Meet May 19 at French Lick

The Kentucky Surgical Society will meet Saturday, May 19, at French Lick, Indiana, according to Francis M. Massie, M. D., Lexington, secretary-treasurer.


Dr. Bowers

Ralph Bowers, M. D., chief of the Surgical Service at the VA Medical Teaching Group Hospital in Memphis, Tennessee, will be the guest speaker. He will discuss "The Surgical Treatment of Chronic Pancreatitis."

Dr. Bowers received his medical degree from Johns Hopkins University in 1925. He served a residency at Cincinnati General Hospital. Since that time he has served as Associate Professor of Clinical Surgery at Cornell Medical School and as Chief of Surgery at Lovell General Hospital and Walter Reed Hospital.

During World War II he served as chief of surgery in the 9th General Hospital in the Southwest Pacific Theater.

Following are names of Kentucky surgeons and the scientific papers they will present at the meeting:

Eugene Todd, Jr., M. D., Lexington; "Carcinoma of the Gallbladder."

W. Burford Davis, M. D., Louisville; "Hiatus Hernia."

D. P. Hall, M. D., Louisville; "Implantation Carcinoma in the Incision Due to Desquamated Malignant Cells."

Everett G. Grantham, M. D., Louisville; "Surgical Measures for Relief of Pain."

Condict Moore, M. D., Louisville; "Neck Dissection."

Alvin B. Ortner, M. D., Louisville; "Management of the Postphlebitic Syndrome."

Houston W. Shaw, M. D., Louisville; "Survival from Cancer."

George A. Sehlinger, M. D., Louisville; "Injury to the Urinary Tract Stressing Those Resulting from Gynecological Surgery."

George B. Sanders, M. D., Louisville; "Evaluation of Patients for Radical Mastectomy by Means of Triple Biopsy and Bone Marrow Biopsy."

The Kentucky Chapter of the American College of Surgeons will meet Friday, May 18, at French Lick. Full details of the meeting will appear in the April Journal.

Louisville Industrial Physician Wins Presidential Award

Gradie Rowntree, M. D., Louisville, Chairman of KSMA's Committee on Industrial Medicine and Surgery, has been awarded the annual Physicians Award of the President's Committee on Employment of the Physically Handicapped.



Dr. Rowntree

The award, a scroll signed by President Eisenhower, was presented to Dr. Rowntree for his "outstanding contribution to the welfare and employment of the physically handicapped."

Dr. Rowntree, a graduate of the University of Arkansas Medical School, is medical director of a Louisville printing company. A professor of industrial medicine at the University of Louisville Medical School, he is vice chairman of the City-County Board of Health and a member of the Governor's Committee on Employment of the Handicapped. Dr. Rowntree was the 1955 President of the Jefferson County Medical Society.

Allied Medical Services Council Opposes HJ Resolution 171

The Kentucky Council for Allied Medical Services went on record, at its January 2 meeting, as opposing the proposed Commission on Nursing which was introduced in the US Congress as HJ 171.

The bill, introduced January 1955 by Congresswoman Francis P. Bolton, proposes to set up a federal study Commission on Nursing Service to gather data on nursing. The commission, which would be composed of 12 members including representatives from the nursing and medical profession, would look into the need to clarify the provinces of both professional and nonprofessional nurses, to improve and extend nursing education and training resources, and to encourage more effective organization and utilization of this personnel.

Mrs. Cynthia Warren, executive secretary of the Kentucky State Association of Registered Nurses, listed several reasons for the opposition of the bill. They are: 1. duplication of what already has been done, 2. delay in pending congressional action required to meet recognized needs, and 3. imposition of a responsibility on the government for an action in areas which should be served by the profession.

Joy McCuddy, president of the KSARN, has asked that all KSMA members assist in defeating HJ 171 when it is brought before the 84th Congress

Physicians representing KSMA at the January 2 meeting were Richard R. Slucher, M. D., Louisville, president-elect Woodford B. Troutman, M. D., Louisville, secretary pro tem; and Everett Baker, M. D., Louisville, vice-president.

Dr. Howard Re-elected President of State Board of Health

E. M. Howard, M. D., Harlan, was re-elected president of the Kentucky State Board of Health, January 20 at a meeting in the Kentucky Hotel.

Thomas P. Leonard, M. D., Frankfort, was named vice-president. The 1936 graduate of the University of Louisville Medical School succeeds J. Watts Stovall, M. D., Grayson. Dr. Stovall's term on the board expired December 31.

Carl Fortune, M. D., Lexington, was sworn in as a new board member. Dr. Fortune, a University of Michigan Medical School graduate, succeeds Dr. Stovall.

Russell E. Teague, M. D., Kentucky's new Commissioner of Health, is secretary of the board.

Ex-Vanderbilt Professor Joins UL Medical School Staff

Beverly Todd Towery, M. D., 41, was recently appointed professor of medicine and chairman of the department of medicine at the University of Louisville School of Medicine. Dr. Towery, associate professor of medicine at Vanderbilt since 1953, succeeds J. Murray Kinsman, M. D., as department chairman.

A native of Springfield, Illinois, and a graduate of Western Kentucky State College, Dr. Towery received his medical degree from Vanderbilt.

After an internship in medicine at Vanderbilt Hospital he served one in pathology at Mallory Institute of Pathology, Boston City Hospital. He served a residency at Massachusetts General Hospital and was a research fellow and resident physician at Thorndike Memorial Laboratory, Boston City Hospital.

Dr. Towery was a major in the Army Medical Corps from 1942-1948.

First Medical Education Week Scheduled for April 23-29

Kentucky physicians are joining with their colleagues all over the nation in celebrating April 23-29 as Medical Education Week. The purpose of the week is to focus national attention on the progress and contributions of the nation's medical schools.

D. P. Hall, M. D., Louisville, Kentucky chairman for MEW, has urged that county medical societies cooperate in working out programs on local levels to get across the purpose of the week.

The week is sponsored jointly by the AMA, the Association of American Medical Colleges, the National Fund for Medical Education and the American Medical Education Foundation.

Pediatrics Seminar Scheduled May 1 Through June 19

The annual pediatric post-graduate course sponsored jointly by the Kentucky State Medical Association, the Department of Pediatrics of the University of Louisville Medical School and the Kentucky Child Health Foundation will be held each Tuesday morning May 1 through June 19 from 9:30 a.m. to 12:30 p.m. at Children's Hospital, Louisville.

The seminar will include talks on such topics as "Office Differential Diagnosis of Fever" by Alex Steigman, M. D., Louisville, and "Febrile Convulsions" by E. Roseman, M. D., Louisville. Panel discussions on the problems of adolescence and the office application of knowledge of the physiology of fluids and electrolytes are included in the seminar program.

The registration fee is $20.00. For more complete information about the course write: W. W. Nicholson, M. D., Department of Pediatrics, 323 East Chestnut Street, Louisville 2, Kentucky.

Pediatricians to Meet April 5

Horace L. Hodes, M. D., Clinical Professor of Pediatrics at Columbia University, will be the guest speaker at the annual scientific meeting of the Kentucky Pediatric Society, April 5, 1956, at the Brown Hotel in Louisville. Dr. Hodes will speak at 3:30 p.m., on "The Etiology and Control of Infantile Diarrhea" and at 7:45 p.m. on "APC Virus Diseases."

A cocktail hour and banquet will follow the business meeting. Members who wish to bring guests can make arrangements by writing to Selby V. Love, M. D., Secretary, 226 East Chestnut Street, Louisville 2, Kentucky. Alex Steigman, M. D., Louisville, is president of the society, and Daniel McIlvoy, Jr., M. D., Bowling Green, is vice-president.

Dr. Lyon is KTH Superintendent

Addie M. Lyon, M. D., Ashland, was named superintendent of the Kentucky Training Home, formerly Kentucky Feeble Minded Institute, February 15.

Dr. Lyon graduated from the University of Louisville Medical School in 1912. Up to 1922 he conducted a private practice and did public health work. Since 1922 he has been superintendent of KMI (1926-1936), superintendent of Western State Hospital, director of the Division of Mental Hygiene and Hospitals in the Welfare Department, acting superintendent of Lakeland Hospital and commissioner of welfare.

Illinois Gives $180,000 to AMEF

The Illinois State Medical Society contributes $180,000 each year to the American Medical Education Foundation. According to the January 1956 ISMS's Secretary's Letter, an annual contribution of $20.00 from each member of the society during '53, '54, and '55 has made a total contribution of $540,000.

Other states have adopted this "Illinois Plan" and approximately seven others have agreed to contribute to the AMEF through their dues.

KSDA Annual Meet is April 8-11

The Kentucky State Dental Association will hold its 96th annual session April 8-11 at the Brown Hotel in Louisville. Jesshill Love, M. D., Louisville, will be the guest speaker from the KSMA.

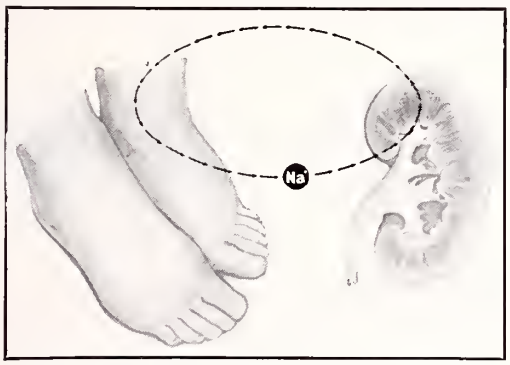
Dr. Love will speak on "The Importance of Leukoplakia as Sub-Lingual Cancer." Among other speakers at the session and the topics they will speak on are: the Reverend Carl Winters, Oak Park, Illinois, "Business of Living"; and Mr. E. C. Lucas, Louisville, "You Can't Straddle a Mudhole with a Wheelbarrow."

The International College of Surgeons will hold a regional meeting of its American section in Madison, Wisconsin at the Loraine Hotel, April 26-28. Arnold Jackson, M.D., president of the association said, in making the announcement, that leading surgeons throughout the US will participate in the program.

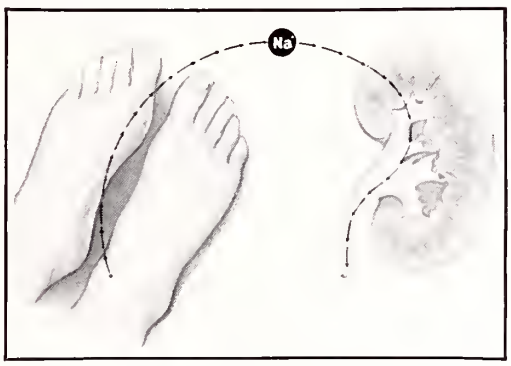
MICTINE* — ORAL NON-MERCURIAL DIURETIC

New Orally Effective Diuretic for Congestive Edema

Best results are obtained when Mictine is administered with meals on an interrupted dosage schedule.



WITHOUT MICTINE — *Prior to diuretic therapy excessive sodium and water are characteristically retained in the edematous patient.*



WITH MICTINE — *Inhibition of the reabsorption of sodium ion leads to an increased excretion of sodium ion, water and chloride.*

An effective diuretic has been described as one which causes excretion of water, sodium and chloride in amounts sufficient to reduce the edema but not to result in salt depletion.

Mictine (brand of aminometradine) introduces to clinical practice an *improved* diuretic which not only meets the standard qualifications but has these seven additional advantages:

Mictine is orally effective; it is not a mercurial; it has no known contraindications; it does not upset the acid-base balance; it exerts no significant influence on electrolyte balance; it may be given in the presence of renal or hepatic diseases; it is well tolerated.

As with most effective therapeutic agents, in high dosage Mictine may cause some side effects in some patients; however, on three tablets daily side effects (anorexia and nausea, rarely vomiting, diarrhea or headache) are minimal or absent.

Clinically, Mictine is useful in the maintenance of an edema-free state in all patients and for initial and continuing diuresis in mild or moderate congestive failure. It is not intended for initial diuresis in severe congestive failure unless either sensitivity or tolerance to other diuretics has developed in the patient.

The maintenance dosage of Mictine, as well as for initial diuresis in mild or moderate congestive heart failure, is one to four 200-mg. tablets daily in divided doses; the dosage for initial diuresis in severe congestive failure, under the conditions already described, is four to six tablets daily. For either use, it is recommended that Mictine be prescribed with meals on interrupted dosage schedules; that is, prescribing Mictine on alternate days or for three consecutive days and omitting it the next four days.

*Trademark of G. D. Searle & Co.

Descriptive literature and clinical trial packages are available on request to . . . SEARLE P. O. Box 5110, B Chicago 80, Illinois

AHA to Meet October 27-31

The 32nd Annual Meeting and the 29th Annual Scientific Session of the American Heart Association will be held in Cincinnati October 27-31, 1956. The scientific program will be conducted at the Music Hall, and the Netherlands-Plaza will be the headquarters hotel.

Kentucky physicians who wish to present papers, based on original investigation in or related to the cardiovascular field, or scientific exhibits, must submit abstracts or make applications to the Medical Director, American Heart Association, 44 East 23 Street, New York 10, New York no later than May 15.

KSA Elects Dr. Threlkel President

F. Hayes Threlkel, M. D., Owensboro, was elected president of the Kentucky Society of Anesthesiologists at their annual meeting Jan. 15 in the Brown Hotel.

Other officers elected for 1956 were: Alfred J. Wagner, M. D., Anchorage, president-elect; Lewis Francis, M. D., Lexington, vice-president; and Robert Lykins, M. D., Louisville, secretary-treasurer. Robert P. Bergner, professor of anesthesiology at the University of Louisville Medical School, was the 1955 president.

Blue Cross Releases Report

The Blue Cross Commission recently released a report showing that as of September 30, 1955, there were 50,179,264 persons enrolled in the 86 Blue Cross Plans in the United States, Canada, and Puerto Rico. The report showed that nearly one out of every three persons in the US today is a Blue Cross member.

Elmer Hess, M. D., AMA President, said, after reading the report, "May the next 25 years prove even more decidedly that free men in a free country are perfectly willing and capable of protecting their families against the cost of medical and hospital care voluntarily without government interference."

Surgeons Hear R. J. Noer, M. D.

"The Obligations of Achievement" was the title of the presidential address given by Rudolf J. Noer, M. D., Louisville, at the 15th annual session of the Central Surgical Society, February 23-25.

Dr. Noer, Professor of Surgery and Chairman of the Department of Surgery at the University of Louisville School of Medicine, made his presentation in Rochester, Minnestota.



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Members of the American Hospital Association and National Association of Private Psychiatric Hospitals

Five modern buildings, separate for men and women. Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD, Hospital Administrator

J. F. HALLER, Manager

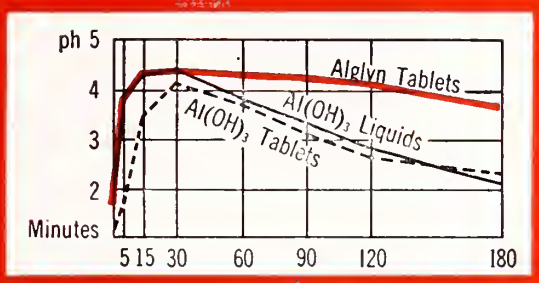
Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M. D., Neuropsychiatrist Medical Director

T. J. SMITH, M. D., Associate

Announcing Revision of N.N.R. Monograph for



ALGLYN®

dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayton PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

More than 500 surgeons, from the central states and south central Canada, and guests of the society were scheduled to attend.

Seven Hospitals Up Room Rates

Seven private Louisville hospitals have raised their room rates. The raises came after a recommendation by the Hospital Conference of Greater Louisville.

The hospitals are: Norton Memorial Infirmary, Kentucky Baptist, Jewish, St. Anthony, Red Cross, SS Mary and Elizabeth, Our Lady of Peace and Kosair.

Topeka MD Speaks to Legislators

Kentucky needs to double its $5,000,000-a-year mental health expenditure—William C. Menninger, M. D., Topeka, Kansas, told State legislators in Frankfort, February 8.

Dr. Menninger, a former president of the American Psychiatric Association, is co-operator of the Menninger Clinic in Topeka and general manager of the Menninger Foundation. Frank Gaines, M. D., Louisville, Kentucky mental-health commissioner, introduced Dr. Menninger.

The American Academy of Neurology will sponsor nine one-day special courses on April 23-25, 1956 at St. Louis, Mo. The Academy will present a special course concerning Common Neurological Syndromes for general practitioners April 25. This course has been authorized by the American Academy of General Practice. For more complete information write to Mrs. J. C. McKinley, Executive-Secretary, American Academy of Neurology, 3501 East 54the Street, Minneapolis 17, Minnesota.

The research grants of the Tobacco Industry Research Committee passed the $838,000 mark in 1955, according to Timothy V. Hartnett, chairman of the committee. This committee sponsors research into tobacco use and health by independent scientists at hospitals, laboratories, and medical schools throughout the United States. A $1,000,000 research fund has been established by the committee.

The 29th Annual Spring Congress in ophthalmology and otolaryngology and allied specialties will be held in Roanoke, Virginia, April 2-7, 1956. Announcement was made by E. G. Gill, M. D., of the Gill Memorial Eye, Ear, and Throat Hospital in Roanoke.

"Neohydrin... offers the striking advantage of a high degree of therapeutic effectiveness upon oral administration."*

*Krantz, J. C., Jr., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, ed. 3, Baltimore, The Williams and Wilkins Company, 1954, p. 998.

98556

NEW CASTLE SANITARIUM
Telephone 3621
NEW CASTLE, KY.

For the care of
CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

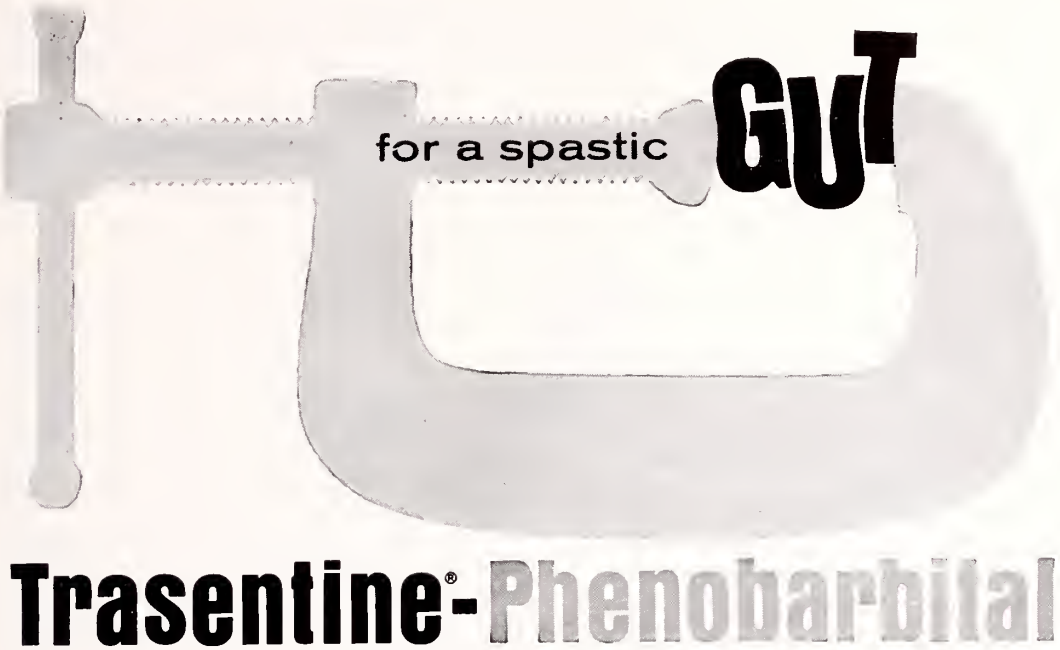
Member of the American Hospitol Associotion
Member of the Americon Assn. of Nursing Homes
Licensed and Approved by the State of Kentucky

SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE
PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS
24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES
New Selectemp Modulated Steam Heat With Filtered Air For Maximum Comfort and Safety
Protected Throughout With Automatic Fire Detection and Alorm System

IRA O. WALLACE, Administrator

PATRONIZE THE ADVERTISERS IN THE JOURNAL



Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

C I B A
Summit, N. J.

2/2228M

THE PEOPLE AND RURAL HEALTH

(Continued from page 264)

were answered by the morning panel and others in the audience. Presentation of the questions from the groups were handled by Walter L. O'Nan, M.D., Henderson, Paul Grubbs, of the Kentucky Chamber of Commerce and Mrs. Cynthia Warren of the Kentucky State Association of Registered Nurses.

The buzz session was followed by a dramatic skit presented by the Kentucky Farm Press and Radio Association arranged by that organization's president, Hayden Timmons of radio station WHAS in Louisville. The skit, which brought out how local rural health councils can serve to foster good health through voluntary cooperation by lay groups, included the following persons in its cast: Ernest Clark, Kentucky farmer; James Heiser, Federal Land Bank; Phyllis Knight, WHAS; Martha Logan, Kentucky College of Agriculture and Home Economics; John Stanford, rural Kentucky; and Mancil Simpson, Kentucky Department of Agriculture.

A stimulating summing up of the conference by Barney Arnold, WHAS farm director, concluded the program.

An evaluation of the 1956 conference is appropriate. Was it a success? From every person we heard who was present, it was the best conference of this type yet held in Kentucky.

Despite the fact that the program had to be altered in many ways and the attendance measurably reduced by the bad weather, the conference was felt to have given real impetus to the rural health council movement in Kentucky.

Perhaps the smooth way in which every one pitched in and made a worthwhile meeting out of a conference which nature seemingly had doomed to failure was an object lesson which showed what we can do ourselves with what we have. Perhaps circumstances forced a special meaning for the conference slogan, "Do It Now With What You Have."

Certainly the attendance and enthusiasm of the people who made the trip should not be lost on the medical

profession. The people want to do something about health. They are willing and eager to do a job of which they are capable when given the benefit of leadership and advice from medical and other health professionals.

The 1956 conference was a real success in the eyes of everyone who attended it. Its democratic purpose deserves the support of every physician in his own community.

WYATT NORVELL, M. D., Chairman
KSMA Committee on Rural Health

EVERY WOMAN
WHO SUFFERS
IN THE
MENOPAUSE
DESERVES
"PREMARIN"®

widely used
natural, oral
estrogen

AYERST LABORATORIES
New York, N. Y. • Montreal, Canada
5645

News Items

Edwin Cameron, M. D., former Delaware State Health Commissioner, has been named director of the Division of Preventive Medicine of the State Department of Health. A native of Nova Scotia, Dr. Cameron was graduated from Dalhousie Medical School, Halifax, Nova Scotia. He received a Master of Public Health Degree from Johns Hopkins University. He has worked in public health in West Virginia; Connecticut; Damacus, Syria and Delaware.

Earl R. Williams, M. D., a native of Indiana, opened an office in Stearns January 18 for the practice of medicine and surgery. A graduate of the College of Medicine Evangelists, Loma Linda, California, Dr. Williams interned at Pawtuckett Memorial Hospital, Pawtuckett, R. I. Dr. Williams served as senior medical officer for two years aboard an aircraft carrier in the Pacific.

Charles Nord, M. D., recently became associated with the Federal Correctional Institute in Ashland. Dr. Nord, who was graduated from the University of Michigan School of Medicine in 1945, interned at the Highland Park General Hospital. Dr. Nord has been on the staff of the University of Michigan Hospital and the VA Hospital in Ann Arbor, Michigan.

Gordon Meade, M. D., a '35 graduate of the University of Rochester School of Medicine, recently joined the staff of the UMW Hospital in South Williamson. Dr. Meade served two internships— Strong Memorial Hospital in New York, and Mt. Morris Tuberculosis Hospital in New York. He was an instructor at the University of Rochester School of Medicine from 1943 to 1946. Dr. Meade served as medical director of the Trudeau Sanitarium, Saranac Lake, New York, from 1946 to 1955.



More physicians have successfully treated more patients for more indications over a longer period of time with tablets of

Cortone®
ACETATE
(CORTISONE ACETATE, MERCK)

HydroCortone®
(HYDROCORTISONE, MERCK)

than with any other adrenal cortical steroid.

SHARP & DOHME
Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

'ANTEPAR'®*



for "This Wormy World"

PINWORMS

ROUNDWORMS

*SYRUP OF 'ANTEPAR' Citrate brand Piperazine Citrate

Bottles of 4 fluid ounces, 1 pint and 1 gallon.

*TABLETS OF 'ANTEPAR' Citrate brand Piperazine Citrate

250 mg. or 500 mg., Scored

Bottles of 100.

Pads of directions sheets for patients available on request.

BURROUGHS WELLCOME & CO. (U. S. A.) INC.
Tuckahoe, New York

Marshall Breath, M. D., has begun a practice in Pikeville. A '40 graduate of the University of Texas Medical School, Dr. Breath interned at the City Memorial Hospital at Winston Salem, North Carolina. He served a residency in internal medicine at the University of Texas Medical School Hospitals.

John F. Weiksnar, M. D., has located at Whitesburg. Dr. Weiksnar was graduated from the University of Buffalo School of Medicine in 1947. He served an internship at the Allied Hospital of Sisters of Charity in Buffalo. He has been associated with the Meyer Memorial Hospital and the US Army Surgical Hospital in Buffalo.

William Evans, M. D., has joined the staff of the UMW Hospital in South Williamson in Pike County. A '38 graduate of the University of Pennsylvania Medical School, Dr. Evans interned at West Pennsylvania Hospital in Pittsburgh. He has been associated with the New York Lying-in-Hospital and the Methodist Hospital in Brooklyn.

Warren Diessner, M. D., a '34 graduate of the University of Minnesoto Medical School, has joined the staff of the UMW Hospital in Middlesboro. Dr. Diessner served an internship at the County Hospital in Hackensack, New Jersey. He was house physician at the Medical Center in Jersey City.

Fred J. Cecil, M. D., has begun a practice in Horse Cave. Dr. Cecil was graduated from the University of Louisville School of Medicine and served an internship at the Kentucky Baptist Hospital. Dr. Cecil practiced in Symposia before going to Horse Cave.

William N. Nash, M. D., recently of the staff of Vanderbilt University Hospital, Nashville, Tennessee, has begun a practice in Louisville. A '52 graduate of the University of Louisville Medical School, Dr. Nash interned at California Hospital in Los Angeles. He served a two year residency in anesthesiology at Columbia-Presbyterian Hospital in New York.

Charles F. Schneider, M. D., a '43 graduate of the University of Virginia Department of Medicine, has begun a practice in Hazard. Dr. Schneider interned at the University of Virginia Hospitals. A surgeon, he has been associated with the VA Hospital in Bradford Virginia, VA Center in Jackson, Mississippi, and the McKenny VA Hospital in Dallas, Texas.

R. Stephen Bowen, M. D., who recently returned from the service, has begun a practice in Mt. Washington. A '52 graduate of the University of Louisville School of Medicine, he interned at th Good Samaritan Hospital in Lexington.

Francis Sommer, M. D., has opened an office in Corbin. A '40 graduate of Yale University School of Medicine, he interned at Boston City Hospital. Dr. Sommer served a residency in OB-GYN at Free Hospital for Women, Brookline, Massachusetts.

Glenn Stoutt, Jr., M. D., a '51 graduate of the University of Tennessee School of Medicine, has opened an office in Evarts. Dr. Stoutt served an internship at the St. Joseph Hospital in Lexington.

COUNTY SOCIETY REPORTS

McCRACKEN

The McCracken County Medical Society held a meeting January 25. Harold Priddle, M. D., president, presided.

The society voted to acknowledge receipt of a copy of a letter from the Calloway County Medical Society which had previously been sent to various state officials concerning the advisability of a second medical school.

Charles Deere, M. D., Assistant Professor of Medicine at the University of Tennessee Medical School, presented the scientific program. He spoke on "Current Uses of Steroids." A question and answer period followed the discussion.

C. P. Orr, M. D., Secretary

PIKE

The Pike County Medical Society held its monthly meeting January 17 in Pikeville. Eighteen members were present.

E. T. Thorsness, M. D., was voted into membership in the society.

Adam G. Osborne, M. D., Pikeville, was elected referee from Pike County to the State Board of Health.

John Archer, M. D., Councilor from the 14th District, reported to the group on the resignation of Bruce Underwood, M. D.; the division of offices of Commissioner of Health and Kentucky State Medical Society Secretary, and appointment of Woodford Troutman, M. D., as secretary pro tem of the KSMA.

Dr. Archer announced that the 14th District Meeting will be held at the Paintsville Club on April 19, 1956.

Ballard W. Cassady, M. D., Secretary

Results With

'ANTEPAR'®*

against PINWORMS

In clinical trials, over 80% of cases have been cleared of the infection by one course of treatment with 'Antepar.'

Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

against ROUNDWORMS

"Ninety per cent of the children passed all of their ascarides . . ."

Brown, H. W.: J. Pediat. 45:419, 1954.

*SYRUP OF 'ANTEPAR' Citrate brand Piperazine Citrate

Bottles of 4 fluid ounces, 1 pint and 1 gallon.

*TABLETS OF 'ANTEPAR' Citrate brand Piperazine Citrate

250 mg. or 500 mg., Scored

Bottles of 100.

Pads of directions sheets for patients available on request.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, New York

SCOTT

The Scott County Medical Society met at John Graves Ford Memorial Hospital in Georgetown, February 2.

The guest speaker, Francis M. Massie, M. D., Lexington, gave the group his views on the proposed UK Medical School.

The following physicians attended the meeting. J. C. Cantrill, M. D.; A. F. Smith, M. D.; F. W. Wilt, M. D.; H. G. Wells, M. D.; C. R. Lewis, M. D.; E. C. Barlow, M D.; and H. V. Johnson, M. D.

H. V. Johnson, M. D., Secretary

SHELBY-OLDHAM

The Shelby-Oldham County Medical Society held its January meeting in the Old Stone Inn at Simpsonville.

The society went on record as favoring increased state aid for the University of Louisville Medical School.

Morgan Colbert, M. D., was the guest speaker. He presented a paper on "Orthopedics in the the office."

The group will hold its next meeting February 23. Nathan Levene, M. D., Hazelwood, will be the guest speaker.

C. C. Risk, D.D.S., Secretary

UNION

The Union County Medical-Dental society held its regular monthly meeting January 17, 1956 at Our Lady of Mercy Hospital in Morganfield.

The group welcomed V. L. Fisher, M. D., into the society. Dr. Fisher recently established a practice in Morganfield. He is a University of Tennessee Medical School graduate.

The following 1956 officers were elected: Dr. Fisher, president; Dudley Smith, M. D., vice-president; William Humphrey, M. D., secretary-treasurer; G. B. Carr, M. D., delegate; and John W. Conway, M. D., alternate delegate.

The members were requested to pay 1956 dues and a suggestion that a speaker be acquired for the February meeting was made. The meeting adjourned at 7:30 p.m.

William Humphrey, M.D., Secretary

The 1956 meeting of the American Goiter Association will be held in the Drake Hotel in Chicago, May 3-5. John C. McClintock, M. D., Albany, N. Y., secretary of the AGA, said in making the announcement, that the meeting will consist of papers and discussions on the physiology and diseases of the thyroid gland.

CITY VIEW SANITARIUM

For the diagnosis and treatment of mental and nervous disorders, alcoholism and drug addictions

Established in 1907 by the late John W. Stevens, M. D.

52 acres near city. Separate buildings for men and women

Two full time psychiatrists

Electric shock and insulin therapy in selected cases

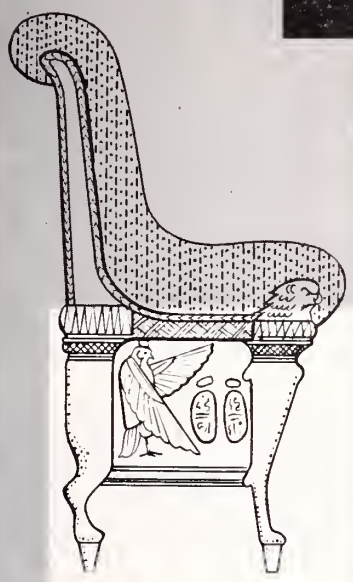
Occupational therapy

Physiotherapy department

Adequate laboratory facilities

NASHVILLE :—: TENNESSEE

FOR HYPERTENSION



"AN ALLIANCE
OF THE CLASSIC
AND CONTEMPORARY"



Synergistic Therapy with New

THEOMINAL® R.S.

Now you can give your hypertension patients the compound therapeutic advantages of two successful hypotensive agents: Theominal (theobromine with Luminal®) and purified Rauwolfia serpentina alkaloids.

THEOMINAL R. S. *gives*
Better Control of Cardiovascular and Subjective Symptoms

Theominal R. S. offers both the vasodilator and myocardial stimulant actions of theobromine with Luminal and the moderate central hypotensive effect of Rauwolfia serpentina. Gentle sedation calms the patient and a feeling of "relaxed well-being" is established. With Theominal R. S. the therapeutic potency of each of the components is enhanced and the chance of a patient's sensitivity to any one drug is lessened.

Each Theominal R. S. tablet contains:

Theobromine	0.32 Gm. (5 grains)
Luminal	10 mg. (⅙ grain)
Purified extract of Rauwolfia serpentina alkaloids	1.5 mg.

DOSE: 1 tablet two or three times daily.

SUPPLIED: bottles of 100 and 500 tablets.

Winthrop LABORATORIES
NEW YORK 18, N. Y. WINDSOR, ONT.

THEOMINAL AND LUMINAL (BRAND OF PHENOBARBITAL), TRADEMARKS REG. U. S. PAT. OFF.

In Memoriam

ROY SCOTT McALLISTER, M. D.

Louisville

1917 - 1956

Dr. McAllister, Louisville surgeon, died at his home Feb. 7 of a heart attack. He was 38.

A native of Finchville, Dr. McAllister graduated from the University of Louisville Medical School in 1943. He served in the Army Medical Corps at Fort Bragg, N. C., during World War II.

A former associate of E. L. Henderson, M.D., once AMA president, Dr. McAllister was associated with Richard Spear, M. D.

V. A. TURNER, M.D.

Lewisburg

1874 - 1955

Dr. Turner died at the Russellville nursing home January 22. He was 81.

A graduate of the University of Louisville Medical Department in 1909, Dr. Turner practiced medicine in Lewisburg for 30 years.

JOSEPH D. NORTHCUTT, M. D.

Covington

1881 - 1956

Dr. Northcutt, president of the Kentucky State Medical Association in 1936, died Jan. 22 at St. Elizabeth Hospital.

A native of Bracken County, Dr. Northcutt moved to Boone County early in life.

He was graduated from the University of Louisville Medical Department.

Dr. Northcutt was a member of the American College of Surgeons and the First Baptist Church in Covington.

MILTON FORD, M.D.

Warfield

1873 - 1955

Dr. Ford died at the Logan General Hospital in December, following a long illness.

A graduate of the University of Louisville School of Medicine in 1904, he began his practice in Inez. Dr. Ford went to Warfield in 1910. He moved his office back to Inez in 1935 where he practiced until a year ago.

Relax the best way

... pause for Coke



continuous quality
is quality you trust

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

Tax Returns
Bookkeeping
Delinquent Accounts (No Commission)
Office Routines
Office Planning
Instructing Personnel
Fees
Partnerships
Hospitals
Clinics
Counselling - Investments Insurance

ASSOCIATES:
Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hubert G. Stiffler
Daniel L. Zeiser
Richard J. Conklin

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945
WOodburn 1-1010
141 West McMillan Street
Cincinnati 19, Ohio

I would like to talk with one of your representatives

Name.....

Address.....

..... Telephone.....

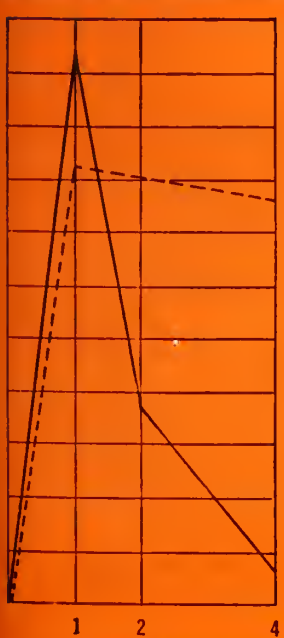
Available

PROFESSIONAL BUSINESS MANAGEMENT

FOR DOCTORS ONLY

All Services Completely Confidential

w! Palatable Oral Suspension Gives
gher, Faster Blood Levels than Twice
Dose of Injected Procaine Penicillin



—— PEN•VEE•*Suspension*, 300,000 units

- - - - Procaine Penicillin G, 600,000 units (one injection)

This ready-mixed, stable, and pleasantly flavored suspension is supplied as follows: PEN•VEE•*Suspension*, 300,000 units per 5-cc. teaspoonful, bottles of 2 fl. oz. Also available: PEN•VEE•*Oral* Tablets, 200,000 units, scored, bottles of 36; 500,000 units, scored, bottles of 12.

PEN·VEE*·*Suspension*

Benzathine Penicillin V Oral Suspension

ORAL PENICILLIN
WITH
INJECTION PERFORMANCE

Wyeth®
Philadelphia 1, Pa.

*Trademark

SECLUSION MATERNITY



FAIRMOUNT HOSPITAL

FOR UNMARRIED GIRLS

Est. 1909

Private sanitarium with certified obstetrician in charge. All adoptions arranged through juvenile court. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

Write for Information

HELEN AMOS

4911 East 27th St.

Kansas City, Mo.

RADIUM

(Including Radium Applicators)

For All Medical Purposes

Est. 1919

Quincy X-Ray & Radium Laboratories

(Owned and Directed by a Physician-Radiologist)

HAROLD SWANBERG, B.S., M.D., Director

W. C. U. Bldg. Quincy, Illinois

WAYSIDE HOSPITAL

168 North Broadway

Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

APPROVED BY AMERICAN MEDICAL ASSOCIATION

STAFF

H. HALBERT LEET, M. D. JOHN H. ROMPF, M. D.

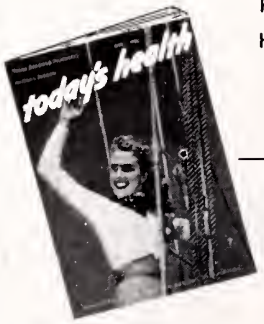
CARL WIESEL, M. D. IRVING A. GAIL, M. D.

EDWARD L. HOUCHIN, ADMINISTRATOR

Phone: 2-2050

today's health a must!

for your reception room



Physicians' Half-Price Rates

4 years	$4.00
3 years	3.25
1 year	1.50

AMERICAN MEDICAL ASSOCIATION

535 North Dearborn · Chicago 10, Illinois

WANTED—General Practitioner who can do some surgery, anaesthesia and obstetrics with a busy General Practitioner in Western Kentucky. Guarantee, and Commission Basis. Address: KSMA. Box, 620 South 3rd St., Louisville, Ky.

PLEASE NOTICE

Advertising space in the Kentucky Medical Journal is worth just what you make it. When you buy from firms advertising in the Kentucky Medical Journal, you protect yourself against questionable products and you increase the value of this, your own Journal, to its advertisers. If a product is not advertised in the Kentucky Medical Journal, it may have been declined in order to protect you. Remember this, and use these pages as your buying guide.

THE NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL (Organized 1881)
(The Pioneer Postgraduate Medical Institution in America)

COURSE FOR GENERAL PRACTITIONERS

Intensive full-time instruction in those subjects which are of particular interest to the physician in general practice, consisting of clinics, lectures and demonstrations in the following departments—medicine, pediatrics, cardiology, arthritis, chest diseases, gastroenterology, diabetes, allergy, dermatology, neurology, minor surgery, clinical gynecology, proctology, peripheral vascular diseases, fractures, urology, otolaryngology, pathology, radiology. The class is expected to attend departmental and general conferences.

SURGERY and ALLIED SUBJECTS

A two months combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the wards post-operatively. Pathology, radiology, physical medicine, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver; attendance at departments and general conferences.

For Information about these and other courses Address

THE DEAN, 345 WEST 50th St., New York 19, N. Y.

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465 **WAbash 6725**
334 W. BROADWAY
LOUISVILLE, KENTUCKY

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**
( ) **Centralized Bookkeeping** (Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

unique
in successfully fighting
malpractice charges

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

LOUISVILLE Office:
Calvin Bimer, Rep.,
Telephone Clay 3636

"The substitution of oral Neohydrin for parenteral meralluride was successfully accomplished in 97 per cent of 70 ambulatory clinic out-patients with chronic congestive heart failure."*

*Lawrence, W. E.; Kahn, S. S., and Riser, A. B.: South. M. J. 47:105, 1954.

98656

Physicianss—Patronize your advertisers for they support the Journal.

the most complete optical service in kentucky

Southern Optical COMPANY
Since 1897
4th and Chestnut
334 W. Broadway
LOUISVILLE

OCULISTS' PRESCRIPTIONS EXCLUSIVELY
MUTH OPTICAL COMPANY
Prescription Opticians
We maintain our own manufacturing and grinding laboratory
665 S. 4th Brown Hotel Building Louisville 2

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS
Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Clearview
On The Kratzville Road
EVANSVILLE, IND.

TELEPHONE 5 6181
A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.
SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

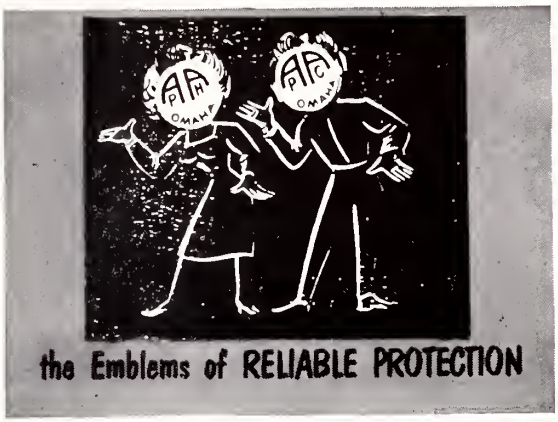
Equipped for Surgery
ELECTROENCEPHALOGRAPH—CLINICAL LABORATORY — EKG AND BMR EQUIPMENT — STEREOSCOPIC X-RAY—HYDROTHERAPY
Albert J. Crevello, M. D.
Diplomate, American Board of Psychiatry & Neurology, Inc
MEDICAL DIRECTOR

BUYERS' GUIDE

Journal of the Kentucky State Medical Association, March, 1956

Abbott Laboratories 206, 207
American Meat Institute 210
Ames Company, Inc. 299
Ayerst Laboratories 278
Bayer Asperin Company 297
Brayton Pharmaceutical Company 275
Brown & Williamson Tobacco Co.....216
Burroughs Wellcome & Company..280, 281
Ciba Pharmaceutical Company 277
Cincinnati Sanitarium 296
City View Sanitarium 282
Clearview Sanitarium 288
The Coca-Cola Company 284
Crocker-Fels Company 294
Fairmount Hospital 286
Chas. B. Knox Gelatine Company.....221
The Keeley Institute 288
Lakeside Laboratories.....222, 276, 287
Lederle Laboratories 250, 251
Eli Lilly & Company.....226
W. R. Long (Insurance Co.).....214
Louisville Medical Dental Business Bureau 287
Mead Johnson & Company.....223, 300
Medical Protective Company.....287
Muth Optical Company 288
National Drug Company 291
New Castle Sanitarium 276
N. Y. Polyclinic Med. Sch. & Hosp.....287
Parke, Davis & Company.....202, 203
Pfizer Laboratories 205, 213
The Phoenix Hotel 295
Physicians Casualty Association.....289
Pleasant Grove Hospital 274
Quincy X-Ray & Radium Laboratories.286
Schering Corporation ..224, 225, 292, 293
Scientific Exhibits 252
Clayton L. Scroggins Associates.....285
G. D. Searle & Company.....273
Sharp & Dohme 211, 217, 279
Smith, Kline & French.....220
Southern Optical Company 288
E. R. Squibb & Company.....298
Today's Health 286
Upjohn Company 219, 295
Wallace Laboratories 215
K.S.M.A. (Want Ad) 286
Wayside Hospital 286
White Cross Hospital 290
Winthrop Laboratories 283
Wyeth, Incorporated 209, 285

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your eligible dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

Adequate Hospitalization for Treatment of Alcoholics

Doctors find the modern facilities and specialized care available at White Cross Hospital meet a vital need.

Affords Sympathetic Atmosphere, Encouraging Personal Attention, Specially Trained Staff

It is generally believed that alcoholism is self-imposed. Often in general hospitals the alcoholic patient is not considered to be "legitimately" sick, which results in the wrong psychological and emotional atmosphere that aggravates the condition. This is why more and more doctors with alcoholic cases where hospitalization is essential are utilizing the facilities at White Cross Hospital, devoted to the treatment of alcoholics exclusively. Here a sympathetic, comfortable and pleasant atmosphere—so essential to rehabilitation—is assured. The White Cross staff, trained in the special problems of the inebriate, is adequate to assure prompt attention at all hours. The White Cross Hospital is under the direction of a competent licensed physician, with five consulting physicians subject to call. Registered nurses and technicians are in charge 24 hours daily.

Safe, Effective White Cross Treatment

A private hospital offering scientific, institutional, medical, psychological, reflex, reduction and other methods for the rehabilitation of consent patients suffering from alcoholism. With the consent of the doctor and patient, the regular White Cross procedure is followed. At your request, your patient remains entirely under your supervision. You may come and go in White Cross Hospital at will, and will find the staff completely cooperative. Your recommendations will be followed to the letter.

All equipment modern with facilities to take care of 50 patients both male and female.



Salem, Va. Hospital

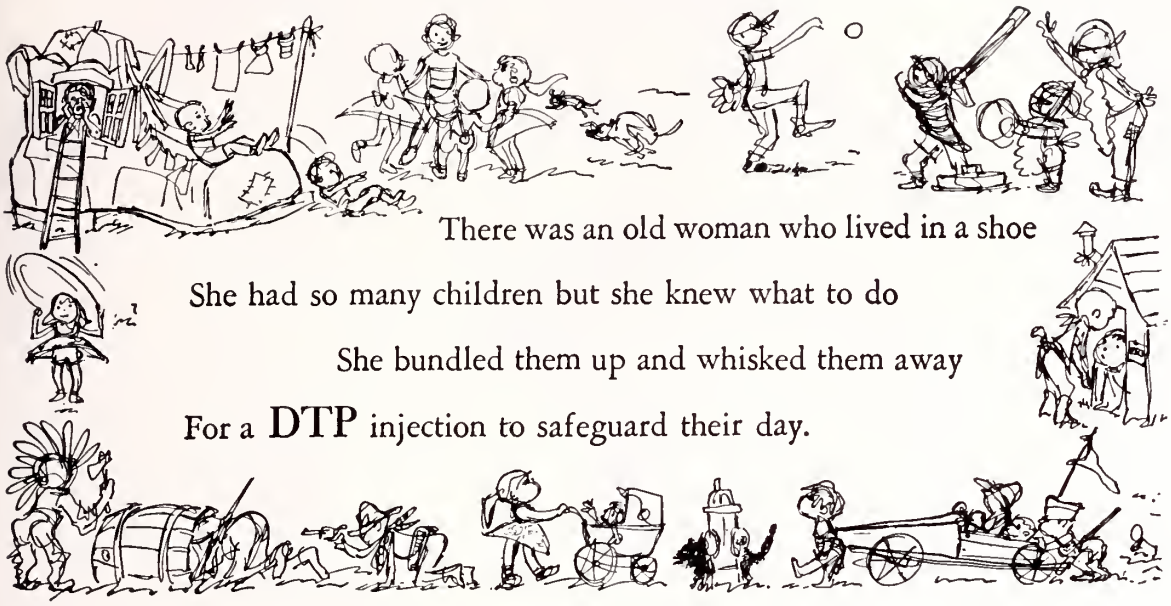
Approved and licensed by the Virginia State Hospital Board, Member American Hospital Association. Located atop beautiful Mt. Regis, in the quiet serene mountains of Virginia—conducive to rest, comfort and rehabilitation.

For information phone or write for booklet
Rates Reasonable

WHITE CROSS HOSPITAL

Five miles west of Roanoke on route No. 11
Salem, Virginia—Phone Salem 4761

Copyright 1955 H.N. Alford, Atlanta, Ga.



- **One complete immunization**
- **99% of nonspecific protein removed**

DTP DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE COMBINED. Alum Precipitated or Plain.

- **Meets most rigid specifications**
- **Freedom from tissue irritation**
- **Maximum antigenicity with minimum of untoward reactions**

Additional products in The National Drug Company's most complete line of biologicals.

TETANUS ANTITOXIN
INFLUENZA VIRUS VACCINE, POLYVALENT
SMALLPOX VACCINE
GAS GANGRENE ANTITOXIN, TRIVALENT
TETANUS-GAS GANGRENE ANTITOXIN, POLYVALENT

☆ LEADING PRODUCERS OF BIOLOGICALS ☆

Tetanus Toxoid, Alum Precipitated or Plain. Diphtheria Antitoxin. Diphtheria Toxin for Schick Test. Diphtheria Toxoid, Alum Precipitated or Plain. Diphtheria and Tetanus Toxoids, Alum Precipitated. Pertussis Vaccine, Alum Precipitated or Plain. Rabies Vaccine. Rhus Tox Antigen. Typhoid Vaccine. Typhoid-Paratyphoid Vaccine. Catarrhalis Combined Vaccine for prophylaxis and treatment of the bacterial complications of the common cold. Staphylococcus-Toxoid-Vaccine Vatox. Strepto-Combined Vaccine. Strepto-Staphylo Vatox. Yellow Fever Vaccine.

Established for Highest Quality

Careful selection and processing of all ingredients under supervision of leading bacteriologists guarantees uniformly high potency, purity and efficacy of each product. Minimum of untoward reactions.

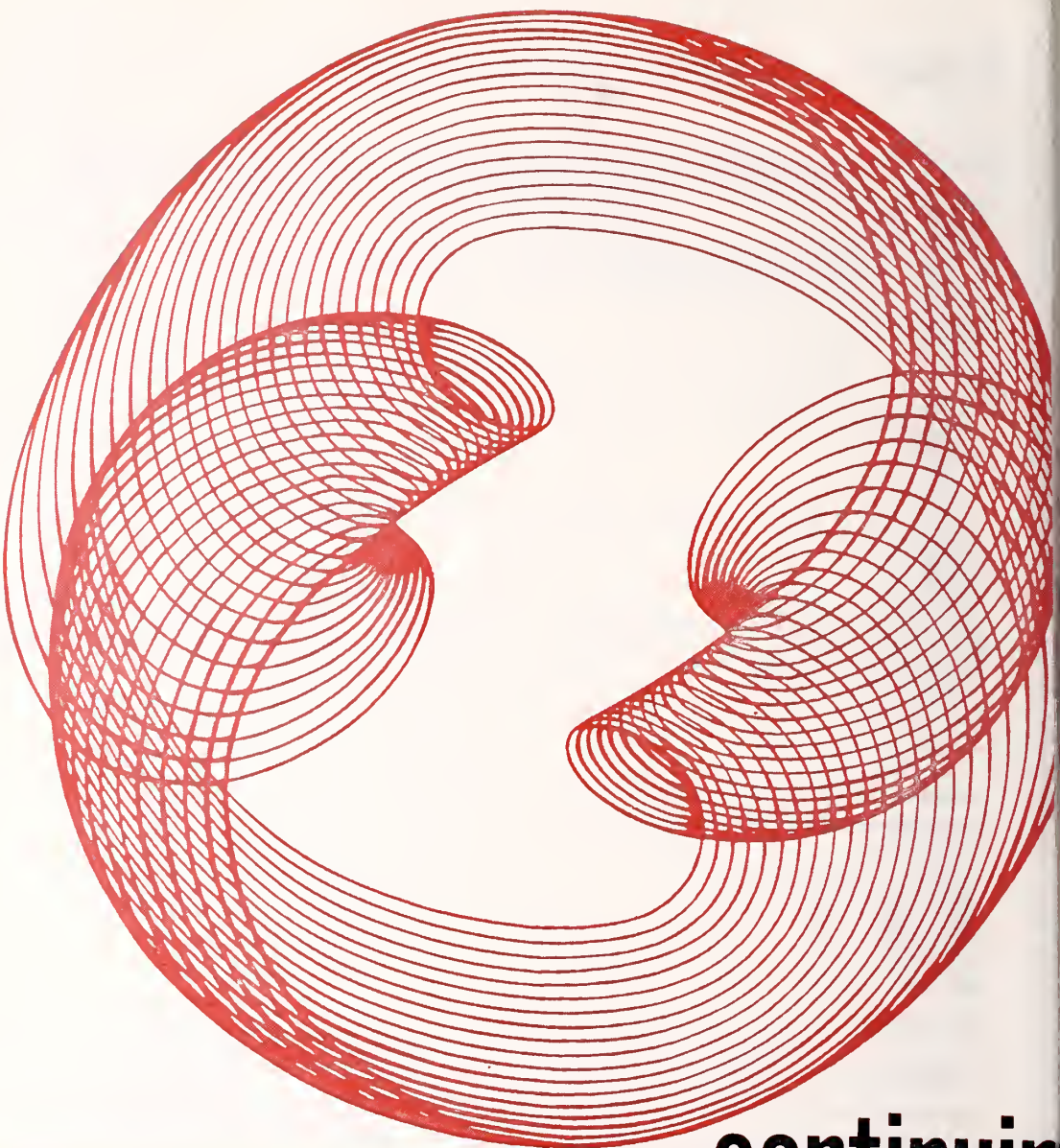
Complete directions, including dosage, route and technique of administration, precautions and contraindications if any, are given in the individual package inserts which accompany each product.

A supply of records of immunizations and tests are available to physicians on request.

PRODUCTS OF ORIGINAL RESEARCH

NATIONAL NATIONAL NATIONAL NATIONAL NATIONAL NATIONAL

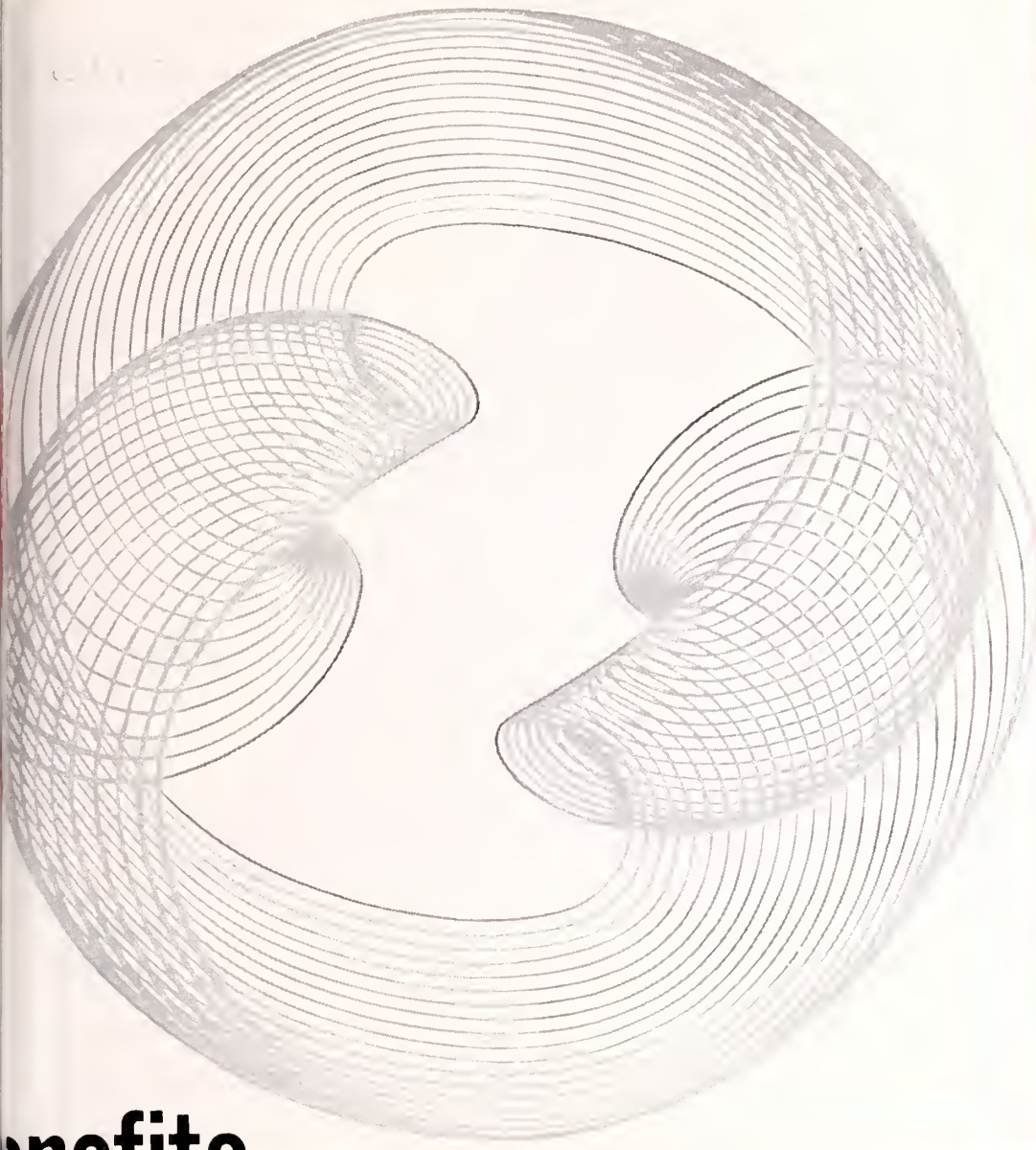
THE NATIONAL DRUG COMPANY PHILADELPHIA 44, PA.



continuin

in corticosteroid thera

for rheumatoid arthritis · intractable asthma
respiratory allergies · collagen diseases
allergic and inflammatory eye and skin disorders



enefits

nificant reduction in electrolyte side effects

METICORTELONE®

OLONE)

Schering

to 5 times as potent as hydrocortisone

na minimized · regimen simplified · more liberal diet permitted

RTELONE is supplied as buff colored tablets of 1, 2.5 and 5 mg., and in capsules of 2.5 and 5 mg.

TELONE ® brand of prednisolone

ML-J-614-356

BURDICK MF-49 UNIVERSAL SHORT WAVE DIATHERMY



You'll like the MF-49 because of its:

1. ability to heat deep tissues effectively,
2. convenience in operating all types of diathermy electrodes,
3. moderate price.

Like Burdick other fine equipment, this unit offers many quality features. Its rubber mounted chasis acts as a cushion to protect tubes and other parts against shock while it is being moved. Its large casters lighten the technician's work. Timing is automatic.

See the MF-49 in our store today.

The **Crocker-Fels** Company

Ask about our liberal financing plan

624 S. THIRD ST. CLay 8855 LOUISVILLE, KY.

The American Regents of the International Board of Proctology announced recently the activation of that Board for the international certification of two classes of applicants. They are: those desiring certification for the practice of proctology either anorectal or anorectal and colopractology; and those seeking certification for proctology within general surgery. For more complete information and applications, write to the offices of the American Regents, 147-41 Sanford Avenue, Flushing, New York.

Upjohn
KALAMAZOO

Indicated wherever oral cortisone or hydrocortisone is effective • Available in 5 mg. tablets in bottles of 30 and 100, and in 1 mg. tablets in bottles of 100 • Usual dosage is ½ to 1 tablet three or four times daily

Delta-Cortef*

Less sodium retention, less potassium depletion

*Trademark for the Upjohn brand of prednisolone (delta-1-hydrocortisone)

Hospitality ————

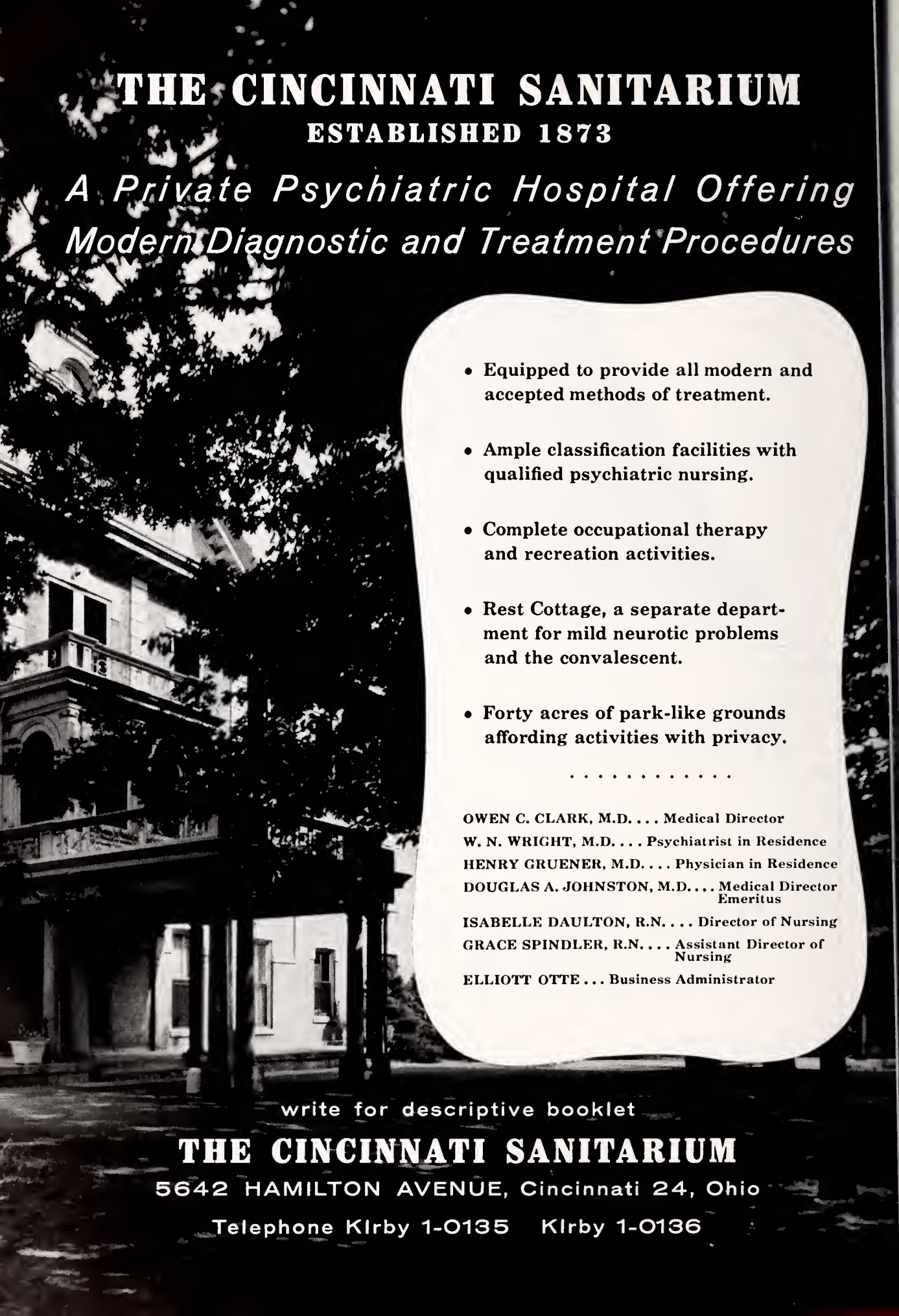
IS WHAT WE PRACTICE
COME AND VISIT US

The Phoenix Hotel

"Lexington's Largest and Finest"

COMPLETED—

Our New Convention Hall of 9600 sq. ft. now available for Trade Shows, Exhibitions, and Large Conventions. Inspection Suggested.



THE CINCINNATI SANITARIUM

ESTABLISHED 1873

A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
- Ample classification facilities with qualified psychiatric nursing.
- Complete occupational therapy and recreation activities.
- Rest Cottage, a separate department for mild neurotic problems and the convalescent.
- Forty acres of park-like grounds affording activities with privacy.

. . . . . .

OWEN C. CLARK, M.D. . . . Medical Director
W. N. WRIGHT, M.D. . . . Psychiatrist in Residence
HENRY GRUENER, M.D. . . . Physician in Residence
DOUGLAS A. JOHNSTON, M.D. . . . Medical Director Emeritus
ISABELLE DAULTON, R.N. . . . Director of Nursing
GRACE SPINDLER, R.N. . . . Assistant Director of Nursing
ELLIOTT OTTE . . . Business Administrator

write for descriptive booklet

THE CINCINNATI SANITARIUM

5642 HAMILTON AVENUE, Cincinnati 24, Ohio

Telephone KIrby 1-0135 KIrby 1-0136



little

How to win friends ...

The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

15¢ Bottle of 24 tablets (2½ grs. each).



We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION

of Sterling Drug Inc.

1450 Broadway, New York 18, N. Y.

the only broad spectrum antibiotic preparation that...



1 provides the antimicrobial activity of tetracycline

Because it contains Steclin (Squibb Tetracycline), the well tolerated broad spectrum antibiotic, MYSTECLIN is an effective therapeutic agent for many common infections. Most pathogenic bacteria, as well as certain large viruses, certain Rickettsiae, and certain protozoans, are susceptible to Mysteclin.



2 protects the patient against monilial superinfection

Because it contains Mycostatin (Squibb Nystatin), the first safe antifungal antibiotic, MYSTECLIN acts to prevent monilial overgrowth frequently observed during broad spectrum antibiotic therapy. Manifestations of this overgrowth may include some of the diarrhea and anal pruritus associated with antibiotic therapy, as well as vaginal moniliasis and thrush. On occasion, serious and even fatal infections caused by monilia may occur.

Mysteclin

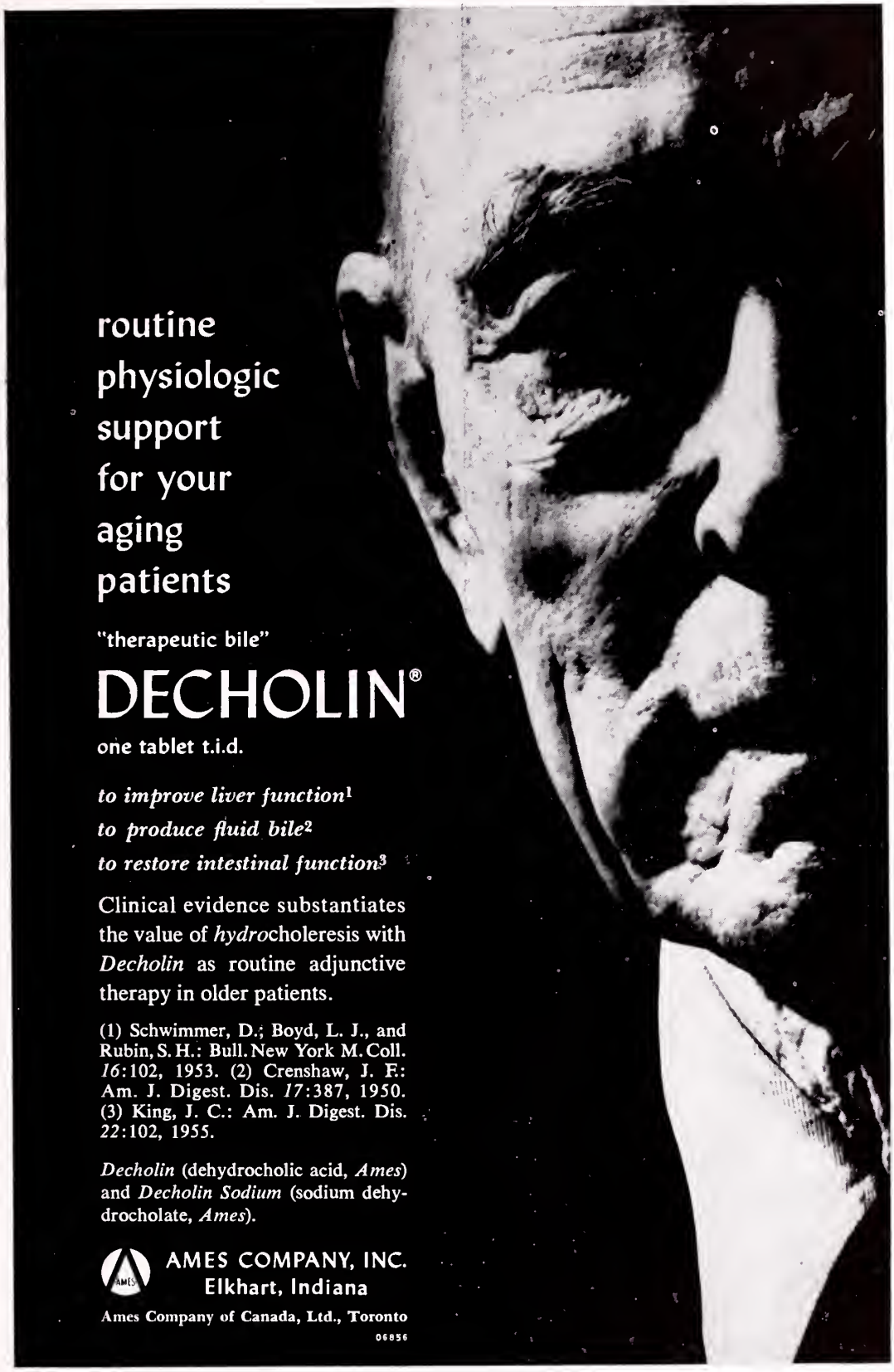
STECLIN-MYCOSTATIN
(Squibb Tetracycline-Nystatin)

Each MYSTECLIN Capsule contains 250 mg. Steclin (Squibb Tetracycline) Hydrochloride and 250,000 units Mycostatin (Squibb Nystatin).

Minimum adult dose: 1 capsule q.i.d. *Supply:* Bottles of 12 and 100.

SQUIBB

"MYSTECLIN", "STECLIN" AND "MYCOSTATIN"® ARE SQUIBB TRADEMARKS


routine
physiologic
support
for your
aging
patients
"therapeutic bile"
DECHOLIN®
one tablet t.i.d.
to improve liver function[1]
to produce fluid bile[2]
to restore intestinal function[3]
Clinical evidence substantiates the value of *hydro*choleresis with *Decholin* as routine adjunctive therapy in older patients.
(1) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. *16*:102, 1953. (2) Crenshaw, J. F.: Am. J. Digest. Dis. *17*:387, 1950. (3) King, J. C.: Am. J. Digest. Dis. *22*:102, 1955.
Decholin (dehydrocholic acid, *Ames*) and *Decholin Sodium* (sodium dehydrocholate, *Ames*).
AMES COMPANY, INC.
Elkhart, Indiana
Ames Company of Canada, Ltd., Toronto
06856



New...improved...

"instant"

Olac®

Powdered high protein formula

is easier to use

New, improved Olac dissolves instantly with water...makes a smooth, good-tasting formula with the briefest shaking or stirring.

...provides satisfying, growth-promoting feedings for

- full term bottle-fed babies
- prematures
- supplementary feedings of breast-fed babies

Olac's milk protein content is exceptionally generous. Its fat is a single highly refined vegetable oil. Curd tension is now reduced practically to zero.

Mead products and services are designed to help you in the varied phases of infant feeding

MEAD

SYMBOL OF SERVICE IN MEDICINE

MEAD JOHNSON & COMPANY, EVANSVILLE 21, INDIANA, U.S.A.

CKS

The Journal OF THE KENTUCKY STATE MEDICAL ASSOCIATION

VOL. 54 APRIL, 1956 NO. 4

COLLEGE OF PHYSICIANS LIBRARY MAY 16 1956 OF PHILADELPHIA

Contents

SCIENTIFIC ARTICLES

GASTRIC ULCER—CRITERIA FOR DETERMINING METHOD OF TREATMENT, Harold J. Kullman, M.D., F.A.C.P. 327

OFFICE MANAGEMENT OF CONDUCTIVE DEAFNESS, Eugene L. Derlacki, M.D. 330

THE CLOSURE OF INTERATRIAL SEPTAL DEFECTS, William H. Muller, Jr., M.D. 336

THE ROLE OF THE MEDICAL DEPARTMENT IN TODAY'S NAVY, O. B. Morrison, Jr., Rear Admiral, MC, USN 338

COMBINED LARYNGECTOMY AND NECK DISSECTION IN CONTINUITY FOR CARCINOMA OF THE LARYNX, Alvin C. Poweleit, M.D., and Robert C. Kratz, M.D. 345

THE USE OF ANTIBIOTICS IN THE TREATMENT OF PULMONARY TUBERCULOSIS, E. R. Gernert, M.D. 347

THE USE OF VARIDASE IN PERFORATING APPENDICITIS, Richard H. Weddle, M.D. 351

CASE DISCUSSIONS 354

EDITORIALS

A PLEA FOR THE FUNDAMENTALS IN SURGERY 357

WHAT KIND OF MEDICAL SCHOOL? 358

ORGANIZATION SECTION

'56 Annual Meeting Plans Announced 359

UMWA Representatives to Meet May 6 359

Physicians Can Now Buy Polio Vaccine 359

Ky. Chapter, ACS Announces Meeting 359

Results of AMA Survey Announced 360

MD Appointed to UK Board of Trustees 360

Pediatrics PG Course is May 1-June 19 360

Student AMA to Hear Col. E. D. Palmer 361

600 Attend National RH Conference 361

MDs Urged to Name Award Candidates 361

Three PG Courses Held in March, April 362

PG Symposium Held in Harrodsburg 362

REGULAR DEPARTMENTS

President's Page 308, In the Books 312, Washington News Digest 318, News Items 370, County Society Reports 372

no nicer way to . . . . . .

SUSPENSION Chloromycetin® PALMITATE

pleasant-tasting CHLOROMYCETIN for pediatric use

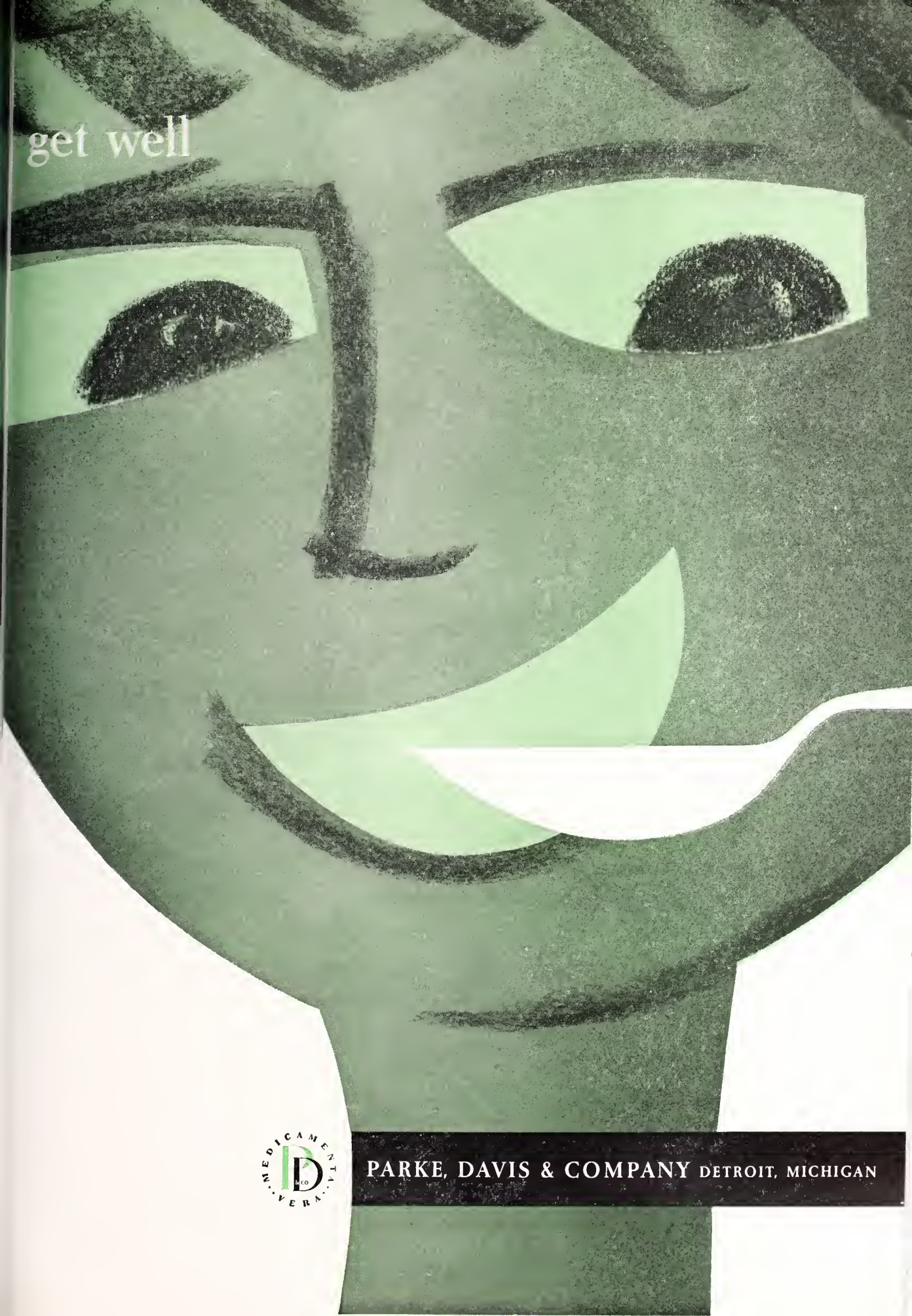
When a youngster's condition calls for CHLOROMYCETIN (chloramphenicol, Parke-Davis) you can make the treatment pleasant by prescribing SUSPENSION CHLOROMYCETIN PALMITATE. Because children like the taste of this custard-flavored suspension, missed doses and spilled doses are avoided. Each teaspoonful is willingly taken...and swallowed.

Precise adjustment of dosage, as directed, is made easier for the child's mother with SUSPENSION CHLOROMYCETIN PALMITATE. The fact that it needs no refrigeration is an added convenience.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

supplied:
SUSPENSION CHLOROMYCETIN PALMITATE,
containing the equivalent of 125 mg.
of CHLOROMYCETIN per 4 cc.,
is available in 60-cc. vials.




get well
MEDICAMENTA VERA
PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

The JOURNAL of the

Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR PRO TEM: W. B. TROUTMAN, M. D. MED. EDITORIAL EDITOR: S. A. OVERSTREET, M.D.
MANAGING EDITOR: J. P. SANFORD BOOK REVIEW EDITOR: WALTER S. COE, M.D.
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D. ORGANIZATION EDITOR: BARBARA N. MORGAN
CASE DISCUSSIONS EDITOR: J. C. BELL, M.D. PUBLISHER: J. G. DENHARDT, BOWLING GREEN

ADVISORY COMMITTEE TO THE EDITOR

Richard J. Rust, M. D. Guy Aud, M. D., Chairman James E. Hix, M. D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1958	Term Expires July 1, 1957	Term Expires July 1, 1956
Henry B. Asman, M.D.	Carey C. Barrett, M.D.	Everett H. Baker, M.D.
Richard Elliott, M.D.	Joe Bush, M.D.	John L. Dixon, M.D.
Rankin Blount, M.D.	Allen E. Grimes, M.D.	George G. Greene, M.D.
Marion F. Beard, M.D.	Richard F. Grise, M.D.	R. Arnold Griswold, M.D.
Glenn Bryant, M.D.	Billy Keller, M.D.	O. Leon Higdon, M.D.
Douglas Scott, M.D.	A. J. Miller, M.D.	James M. Keeton, M.D.
William C. Buschemeyer, M.D.	Robert Reeves, M.D.	Frank Moore, M.D.
Harry D. Abell, M.D.	Charles R. Yancey, M.D.	Alvin C. Poweleit, M.D.

Editorial and Business Offices, 620 S. Third St., Louisville, Kentucky

Subscription $6.00 per year Single Copy .80

KENTUCKY STATE MEDICAL ASSOCIATION OFFICERS—1955-56

Gant Gaither, 109½ East 7th Street, Hopkinsville ..... President
Richard R. Slucher, Buechel..... President-Elect
Clyde C. Sparks, M.D., Mayo Arcade Ashland..... Immediate Past President
Everett Baker, 408 Brown Bldg., Louisville..... Vice-President
Nathaniel Bosworth, 117 S. Ashland, Lexington..... Vice-President
Howell J. Davis, 330½ Allen, Owensboro..... Vice-President
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Secretary-Editor Pro tem
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Treasurer
Charles A. Vance, 271 W. Short Street, Lexington ..... Speaker—House of Delegates
E. W. Jackson, 333 Broadway, Paducah..... Vice Speaker—House of Delegates
J. Vernon Pace, 709-10 Citizen's Bank Bldg., Paducah ..... Chairman of the Council
Delmas M. Clardy, Hopkinsville..... Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan.....	1956
Alternate to be Appointed	1956
W. Vinson Pierce, 33 E. Seventh St., Covington.....	1957
Leon Higdon, 333 Broadway, Paducah, (Alternate)	1957

COUNCILORS

		Term Expires
First District.....	J. Vernon Pace, 709-10 Citizens Bank Building, Paducah.....	1956
Second District.....	Walter L. O'Nan, 700 N. Elm St., Henderson.....	1958
Third District.....	Delmas M. Clardy, Hopkinsville.....	1956
Fourth District.....	W. Keith Crume, Bardstown.....	1956
Fifth District	Carlisle Morse, 3612 Lexington Road, Louisville.....	1957
Sixth District.....	L. O. Toomey, 544 E. Main St., Bowling Green.....	1957
Seventh District.....	Branham B. Baughman, 401 W. Main St., Frankfort.....	1958
Eighth District.....	Edward B. Mersch, 92 Arcadia, Covington.....	1957
Ninth District.....	J. M. Stevenson, Brookville.....	1958
Tenth District.....	J. Farra Van Meter, 183 N. Upper Street, Lexington.....	1958
Eleventh District.....	Hugh Mahaffey, Richmond.....	1957
Twelfth District.....	Garnett J. Sweeney, Liberty.....	1956
Thirteenth District.....	Charles B. Johnson, Russell.....	1958
Fourteenth District.....	John Archer, Prestonsburg.....	1956
Fifteenth District.....	Charles B. Stacy, Pineville.....	1957

Entered as second-class matter, Oct. 22, 1906, at the Post Office at Bowling Green, Ky., under act of Congress, Mar. 3, 1897. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.



ideal endocrine "companion"
for menopausal patients



comforts—Controls major symptoms within 6 to 10 days, hot flushes in as few as 3 days.

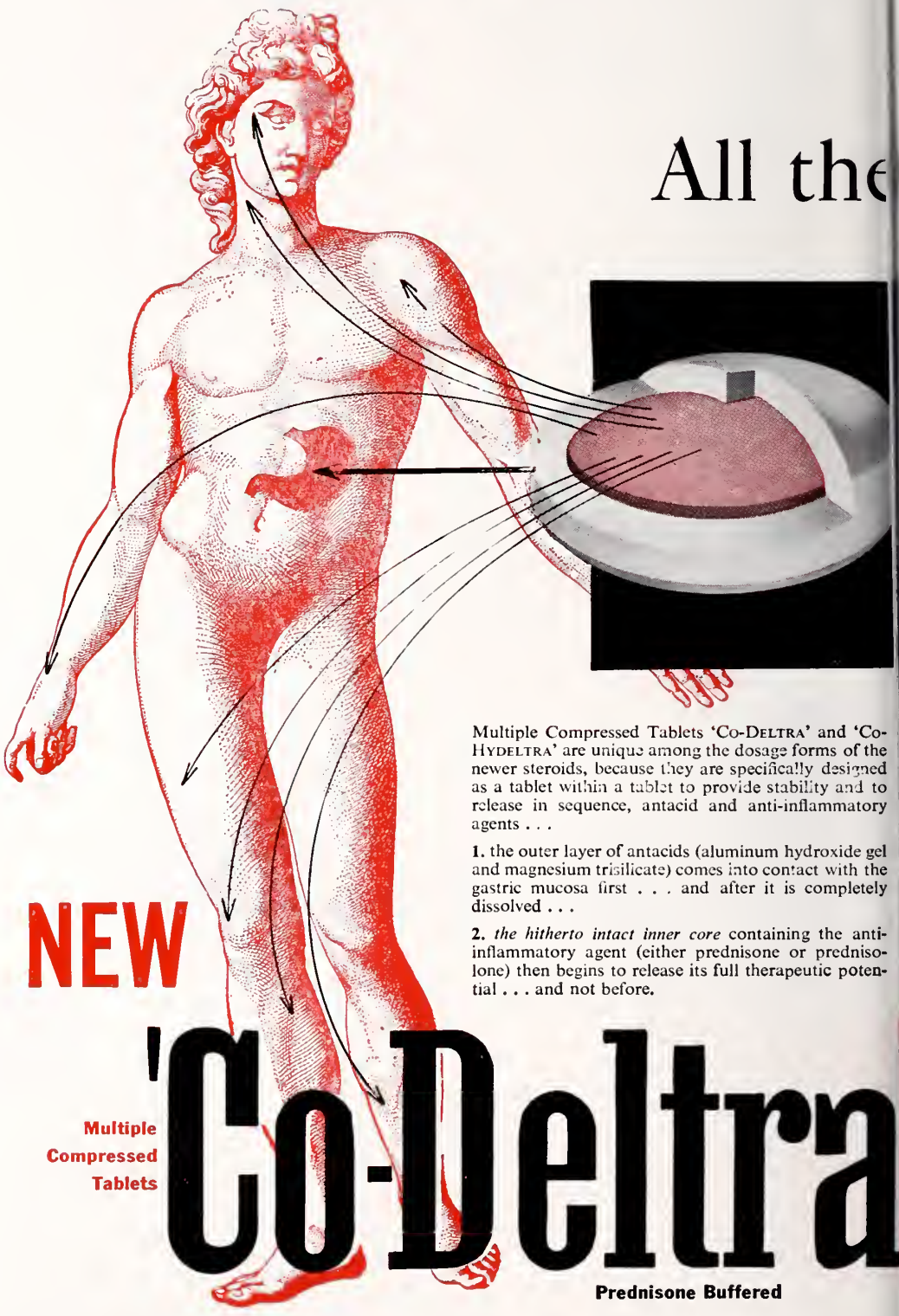
cheers—Confers a welcome feeling of physical vitality and mental well-being.

compatible—Much less prone to cause the side effects so often experienced with stilbene derivatives.

thrifty—Does "a better job at far less cost" and is "much better to use than any of the so-called naturally conjugated estrogens."*

* Clinton, M., Round Table Discussion: New York J. Med. *54*:481, 1954.
ESTINYL.® brand of Ethinyl Estradiol U.S.P.

EE-J-61 356



All the

Multiple Compressed Tablets 'Co-DELTRA' and 'Co-HYDELTRA' are unique among the dosage forms of the newer steroids, because they are specifically designed as a tablet within a tablet to provide stability and to release in sequence, antacid and anti-inflammatory agents . . .

1. the outer layer of antacids (aluminum hydroxide gel and magnesium trisilicate) comes into contact with the gastric mucosa first . . . and after it is completely dissolved . . .

2. *the hitherto intact inner core* containing the anti-inflammatory agent (either prednisone or prednisolone) then begins to release its full therapeutic potential . . . and not before.

NEW

Multiple Compressed Tablets

'Co-Deltra

Prednisone Buffered

benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress...

A reportedly higher incidence of gastric distress in patients receiving the newer steroids prednisone and prednisolone indicates the desirability of co-administering non-systemic antacids.[1]

To help the physician cope with this problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids . . . Multiple Compressed Tablets 'CO-DELTRA' (Prednisone Buffered) and 'CO-HYDELTRA' (Prednisolone Buffered) are now available.

'CO-DELTRA' and 'CO-HYDELTRA' are now available in bottles of 30 on your prescription. Each Multiple Compressed Tablet contains:

Prednisone or Prednisolone, 5 mg.; 300 mg. of dried aluminum hydroxide gel, U.S.P., and 50 mg. of magnesium trisilicate.

'CO-DELTRA' and 'CO-HYDELTRA' are trade-marks of MERCK & CO., INC.

1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* **158**: 459, June 11, 1955.

Co-Hydeltra'

Prednisolone Buffered

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

President's Page

As one of your vice presidents, it is my privilege to write one edition of the President's Page. The more thought I have given to this, the more I am aware of my inadequacy to fulfill such a mission. However, there are several points that have occurred to me that have been of help in the daily problem of doctor-patient relationship.

So many times under the pressure of a busy day, we have a tendency to hurry by our patients without giving them a chance to be heard. A few more minutes of our time in interested understanding may make the difference between a satisfied patient and a disgruntled one.

Most patients these days expect frankness from their doctor, and I believe that most doctors today feel that the patients have a right to know what they are up against. Here again a little time taken to explain the patient's illness in frank and sympathetic terms will go a long way in gaining that patient's confidence and giving him satisfaction.

I would like to pass on an approach which has been of help in talking fees with patients. It is many times wise (particularly in discussing operative fees) to explain to the patient that this type of service is worth a certain amount of money, but that not all people can afford to pay the actual worth. Therefore, the fee often is graded downward in accordance with the patient's ability to pay.

We believe that fees should be discussed frankly with patients and should not be handled in a way that creates embarrassment or discourages discussion of them on the part of the patient.

N. LEWIS BOSWORTH, M.D.
Vice President



Re-activate the arthritic

MOST POTENT ANTI-RHEUMATIC *

Sterane

Even where hydrocortisone, cortisone, and other agents had failed, prednisolone (STERANE) restored articular mobility and functional capacity to normal in rheumatoid arthritis.[1]

Four times more effective than hydrocortisone, and, on the basis of preliminary findings,[2,3] superior in potency even to prednisone (cortisone analog), STERANE is also relatively free of such hormonal side effects as edema, hypertension, or hypopotassemia.

Supplied: White, 5 mg. oral tablets, in bottles of 20 and 100. Pink, 1 mg. oral tablets, in bottles of 100. Both are deep-scored and in the distinctive "easy-to-break" size and Pfizer oval shape.

References: 1. Bunim, J. J., et al.: J.A.M.A. 157:311, 1955. 2. Forsham, P. H., et al.: Paper presented at First Internat. Conf. on Prednisone and Prednisolone, New York, May 31-June 1, 1955. 3. Perlman, P. L., and Tolksdorf, S.: Scientific Exhibit presented at A.M.A. Annual Meet., Atlantic City, June 6-11, 1955.

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

*brand of prednisolone



KARO® SYRUP . . . meets the need for an easily digested milk modifier

Since the newborn infant has very little ability to digest starchy foods, the carbohydrate requirements of the formula-fed baby are best met with a milk modifier which places a minimum demand on the digestive system.

Karo syrup has been a carbohydrate milk modifier of choice for three generations. Because it is a balanced mixture of dextrins, maltose and dextrose, it enables the feeding of larger amounts of total carbohydrate without producing gastro-intestinal disturbances.

Other characteristics that commend the use of Karo for milk modification are—the ease with which formulas may be calculated or prepared—its ready availability—and its economy. Light or dark Karo syrup may be used interchangeably with cow's milk or evaporated milk and water. Each fluid ounce (2 tablespoonfuls) yields 120 calories of solid nutrition.



1906 • 50th ANNIVERSARY • 1956
CORN PRODUCTS REFINING COMPANY
MEDICAL DIVISION
17 Battery Place, New York 4, N. Y.

in rheumatoid arthritis

METICORTEN
(PREDNISONE)

Schering

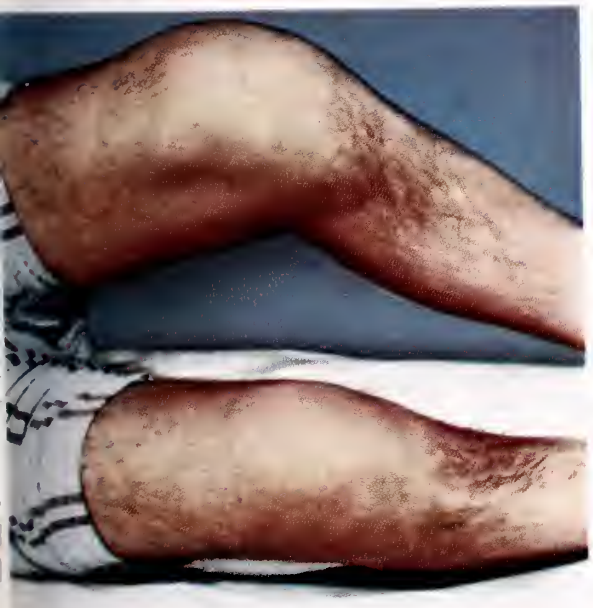
results—*excellent* · edema—*rare*



Deformed hands of woman with rheumatoid arthritis before therapy. Unable to open hands.



After two weeks on METICORTEN, *patient is free of pain and can open hands completely.*



Acutely swollen, painful knees in man with rheumatoid arthritis before therapy.



After two weeks on METICORTEN, *swelling of knees is gone and patient can walk without difficulty.*





in corticosteroid therapy permits treatment of more patients

- rarely causes edema or electrolyte side actions
- 3 to 5 times more potent, milligram for milligram, than hydrocortisone or cortisone
- excellent relief of pain, swelling, tenderness; diminished joint stiffness—in rheumatoid arthritis
- excellent relief of bronchospasm, dyspnea, cough; increased vital capacity in asthma
- hormone benefits in respiratory allergies, inflammatory and allergic eye and skin disorders, collagen diseases

METICORTEN is available in 1 mg., 2.5 mg. and 5 mg. white tablets, and as 2.5 mg. and 5 mg. capsules.
METICORTEN,* brand of prednisone.

MC-J-614-356 *T.M.

24-hour control

for the majority of diabetics



GLOBIN INSULIN

'B.W. & CO.'®

a clear solution . . . easy to measure accurately

Discovered by Reiner, Searle, and Lang
in The Wellcome Research Laboratories

BURROUGHS WELLCOME & CO. (U.S.A.) INC. • Tuckahoe 7, New York



REVIEW ON MODERN TREATMENT—Edited by Austin Smith, M. D., and Paul Wermer, M. D., Horber-Harper, 1146 pages.

A book, easy to read and understand, is a pleasure to any practitioner. Such a book is "Modern Treatment."

The 53 authors, all eminent in their field, take little for granted. Each chooses the accepted therapy, and pertinent related facts regarding etiology and pathology are given. The authors state their opinions clearly without controversial views.

To choose a good exemplary chapter is to pick any in the book, for instance, that by George T. Hurrell, M. D., on "Infection." First, it is discussed from the point of severity, recovery, clinical pattern, growth of organism in the body, etiological diagnosis and other phases, all leading to specific therapy of a specific disease; including the choice of drugs with exact dosage, as well as other methods in present day use. A worthy example of specific diseases is whooping cough. He covers the field of therapy from the supportive, specific, chemical and immune aspects, followed by special measures in the usual and complicated cases. As previously mentioned, little is taken for granted, therefore, when a procedure is discussed sufficient detail is incorporated to clarify and assure good management. Finally the features of immunization are thoroughly considered.

Modern therapy is the key note; yet, the authors make it abundantly clear that only procedures and drugs which have stood the test of time are used. It is heartening to note that relatively few and simple preparations are advocated throughout the book, in contrast to the hundreds of "new products" marketed currently.

The book consists of 51 chapters, of more than 1100 pages and is well indexed to facilitate reference. It is written by a group of postgraduate teachers who bring out bedside-everyday problems in a manner somewhat different than the standard text. In addition to internal medicine, pediatrics, obstetrics and gynecology, eyes, ears, nose and throat surgery there are references related to geriatrics, physical medicine, diagnostic technics, physician and patient relationship, medicine and the law; to mention a few, which usually are not incorporated in a reference book.

As a "Guide for General Practice" the editors, S. Austin Smith, M. D., editor of the Journal of the AMA and Paul L. Wermer, M. D., secretary of the Committee of Research of the AMA are to be complimented on a fine production and a contribution to the busy family physician.

M. R. Cronen, M.D.

ESSENTIALS OF ORTHOPAEDICS—by Philip Wiles, M. D., F.R.C.S., F.A.C.S., Second Edition; pp xv+538, with 393 figures and 7 color plates; 1955; Boston: Little, Brown and Company; Price $10.00

This is a well organized and concise text-book on orthopaedic subjects. Although rare conditions are mentioned, they are discussed as briefly as possible. Detailed operative procedures, of principal interest to the specialist, are not included.

The section on shoulder girdle pain is excellent in its clarity of classification and conciseness of presentation. Of no less interest to the general practitioner, as well as the student of orthopaedics, are the many excellent illustrations.

A discussion of fracture and dislocations of the skeleton is not included in this treatise. To cover this subject would require more than a single volume. The medical aspects of orthopaedics are fully discussed, including their application to diagnosis and treatment. There is no bibliography included for the subjects covered.

Division of the chapters into anatomical units such as the spine, the hip, etc., and discussion of diseases, such as arthritis, tumors and pyogenic infection, in separate chapters makes this text especially easy to use as a reference.

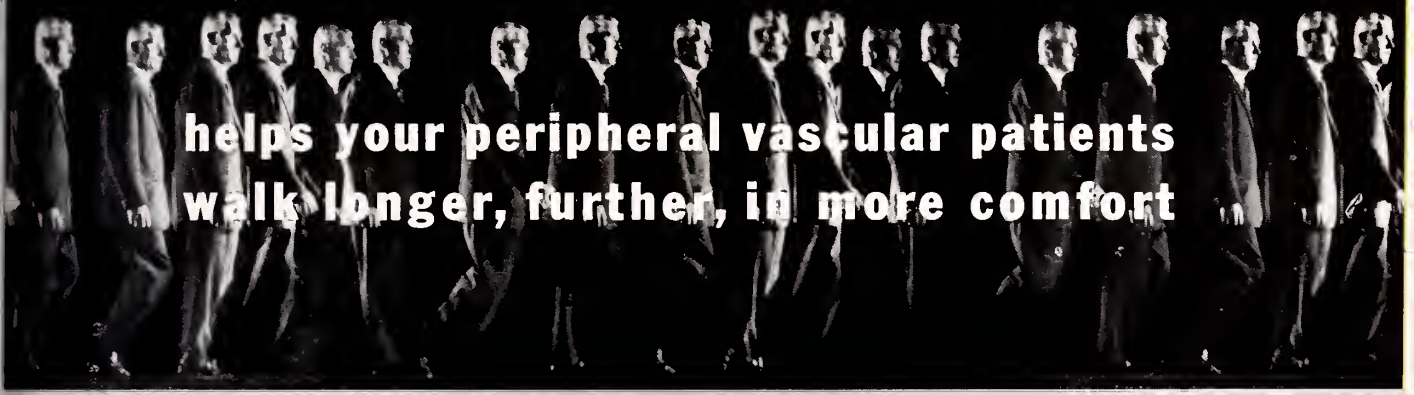
This book is very easy to comprehend and stimulates the reader's interest with a variety of conditions which are commonplace. It is, indeed, an essential text-book in every physician's medical library.

W. M. Ewing, M.D.

brand new

arlidin

vasorelaxation
more tissue oxygen
improved muscle metabolism
pain relief
well tolerated • rapid • sustained



"strong muscle vasodilator activity and an adequate increase in cardiac output"[1]

effective "vasodilative agent of minimal toxicity and optimal tolerance"[2]

in intermittent claudication
diabetic vascular disease
Raynaud's disease
thromboangiitis obliterans
ischemic ulcers
night leg cramps

ARLIDIN dilates peripheral blood vessels in distressed muscles, relaxes spasm, increases both cardiac and peripheral blood flow . . . to send more blood where more blood is needed.

dose: 1 tablet t.i.d. or q.i.d.
bottles of 50, 100 and 1000.



arlidin* HCl
brand of nylidrin hydrochloride
tablets **6 mg.**

1. Pomeranze, J. et al.: Angiology, June, 1955.
2. Freedman, L.: Angiology 6:52, Feb. 1955.

Write for samples and literature

arlington-funk laboratories
division of U. S. Vitamin Corporation
250 East 43rd Street, New York 17, N.Y.

*Trade Mark

SOCIALIZED MEDICINE

May never come, but. . . Socialized Insurance is here to stay, and it has created a sizable Estate Handicap against the physician.

In the case of a young doctor with young children, this economic penalty may be as high as $40,000.00

But there is a solution, and the cost is no greater than the Social Security Tax. Write now for complete information

— — — — — — — — — — —

W. R. LONG & ASSOCIATES

1534 Bardstown Road—Louisville, Ky.

Without obligation to me I would like to have more information about the solution to the Social Security problem of the young doctor. I am in good health and was

born .....
Month Day Year

Name.....

Address.....

CHRISTOPHER'S MINOR SURGERY—by Alton Ochsner, M. D., F.A.C.S., and Michael E. DeBakey, M. D., F.A.C.S.: W. B. Saunders Co.; 547 pages; 1955; $9.00.

This book consists of 547 pages organized into seven major systems with subgrouping of the various disorders affecting each system. Twenty-one authors have collaborated in preparation of the text. All are, or have been, members of Tulane or Baylor University Schools of Medicine. This close association of authors is apparent in the good correlation of material presented. The present text has been extensively revised, keeping pace with surgical progress since publication of the last edition seven years ago.

The opening chapters are concerned with surgical equipment, types of sterilization, dressings and bandages, and anesthesia. Basic surgical techniques and minor surgical procedures are portrayed.

Chapter five, entitled "The Surgical Resident" presents a clear picture of how one can derive the most from his training experience. It should be read by all engaged in or contemplating taking a surgical residency.

Many parts, such as the one on "Arterial Diseases" are excellent. They stress the symptoms, signs, and pathologic physiology of each disease. The recent interest in vascular disease and newer methods of treatment make careful study of this chapter worthwhile.

Diseases of veins and lymphatics are discussed in detail, including anatomy, the physiology of venous disorders, available diagnostic tests and the types of therapy now employed.

Office proctology, especially as related to diagnosis, is an outstanding section. The technique of digito-rectal examination, so often painfully performed, is even set forth.

Throughout the text there is an effort to limit discussion to minor surgical problems. The difficulty of determining what may be minor or major surgery is evident, for many major surgical problems are included, particularly from a diagnostic viewpoint. Here again, attempts are made to define what can be done in the office and what should be performed in the hospital.

It is a book that will be valuable for surgeons as well as for many general practitioners, who because of geographical location, must perform many minor surgical procedures.

Harold E. Kleinert, M.D.

pronounced

MUSCLE-RELAXING ACTION

Equanil*

MEPROBAMATE

(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

LICENSED UNDER U.S. PATENT NO. 2,724,720

For significant relief in myositis, osteoarthritis, backstrain, and related conditions marked by:

- ***Muscle spasm***
- ***Stiffness and tenderness***
- ***Restriction of motion***
- ***Pain***

As a superior muscle-relaxant, EQUANIL offers predictable action and full effectiveness on oral administration. It does not disturb autonomic function and is relatively free from gastric and other significant side-effects. Its anti-anxiety property provides important correlative value.

Usual dosage: 1 tablet t.i.d. The dose may be adjusted either up or down, according to the clinical response of the patient.

Supplied: Tablets, 400 mg., bottles of 50.

Wyeth®

Philadelphia 1, Pa.

anti-anxiety factor
with muscle-relaxing action
...relieves tension

KNOX Protein Previews



New Booklet Presents
Latest Facts on Feeding the Sick



Adequate nutrition during illness and convalescence is essential for recovery whether the patient is managed in the hospital or at home. In the latter case, physicians often must devote much time to instructing those responsible for caring for the sick in good nutritional practices.

"Meal Planning for the Sick and Convalescent" has been designed to relieve you of the need for repeating over and over again essential dietary facts. This new Knox booklet presents in layman's language the latest nutritional applications of proteins, vitamins and minerals, gives practical hints on serving food to adults and children, suggests ways to stimulate appetite and describes diets from clear liquid to full convalescent. Best of all it offers the homemaker for the first time detailed daily suggested menus for each type of diet, plus 14 pages of tested nourishing recipes.

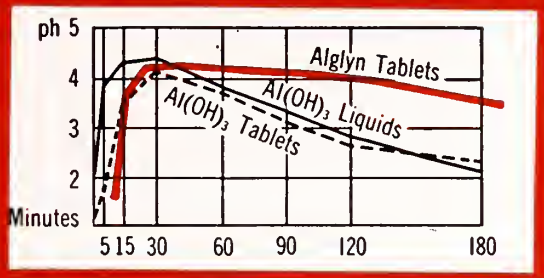
If you would like copies of this new timesaving Knox booklet for your practice, use the coupon below.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Department SJ-16
Johnstown, N. Y.

Please send me.....copies of the new Knox "Sick and Convalescent" booklet.

YOUR NAME AND ADDRESS

Announcing Revision of N.N.R. Monograph for



2

ALGLYN®

dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayten PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

WASHINGTON NEWS DIGEST

Washington, D. C.—A little-publicized study group of eight physicians and scientists has submitted a report to the Secretary of Health, Education, and Welfare that promises to stimulate considerable debate by all interested in medical research, including members of Congress.

The committee was appointed by the National Science Foundation a year ago at the request of former HEW Secretary Hobby for "a critical review" of the scope and distribution of all phases of medical research where U. S. funds are used. Heading the committee was Dr. C. N. H. Long of the Yale School of Medicine.

Three basic proposals of the committee:

1st, that research within the National Institutes of Health research be levelled off, and policy and personnel matters there be brought under the scrutiny of an advisory board of non-governmental medical scientists.

2nd, that other research under the Public Health Service, including teaching grants to institutions and fellowships, be put under a new Office of Medical Research and Training reporting directly to the HEW Secretary and out-side the control of PHS.

3rd, that emphasis be placed on general research rather than the present trend of specific grants for specific disease studies, the so-called categorical approach.

On receipt of the report, Secretary Folsom promised it would be studied "intensively" both by HEW and PHS officials, but he set no time deadlines.

The Long Committee noted the tremendous growth in federal medical research during and since World War II and the increasing role played by PHS. While conceding that PHS has done its job effectively, the committee felt that the time has come to re-examine the concentration of activities under one agency.

On its first point the committee said NIH is making a major contribution in medical research and that senior appointments there should actually become "the most sought after in the country." It suggested legislation that would permit employment of research scientists at the Institute without regard to commissioning in the PHS Corps or salary limitations imposed by civil service.

On its second basic proposal, the committee recommended that the new agency have authority over (a) unrestricted, long-term institutional grants, (b) grants for research, both categorical and non-categorical (c) fellowships and traineeships in medical and related areas, and (d) grants for construction of research and teaching facilities.

Commenting on the categorical approach to research, the committee said the public has been "led to believe, consciously or unconsciously, that the donation of sufficient sums of money is all that is needed to eradicate diseases which have plagued mankind for centuries."

In Congress, any move away from categorical grants in medical research is certain to produce fireworks. Some Senators and Representatives believe it's Congress' responsibility to pinpoint where money it appropriates is to be spent, and they are not inclined to make an exception for research money.

Two bills on military medical legislation went through the House without change, after detailed hearings and study by a subcommittee. The expectation is that action on them will not be long delayed in the Senate.

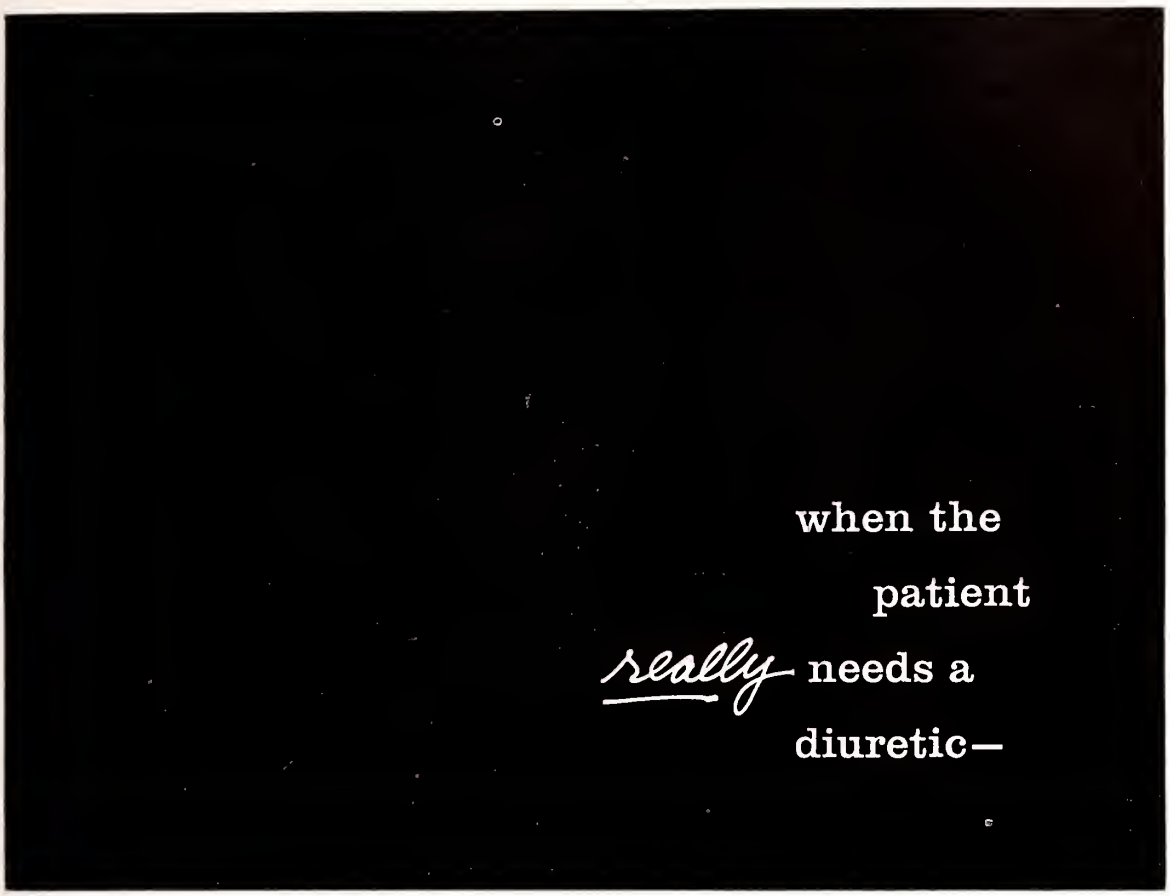
One is designed to make military medical careers more attractive by allowing credit for time spent in medical school and internship, and setting up a series of three $50 per month raises after three, six and 10 years, service. These would be in addition to the present $100 per month special pay for medical officers. Public Health Service medical officers would benefit, as well as those in Army, Navy and Air Force.

The other bill well on its way to becoming a law allows dependents of servicemen to receive private hospital and medical care, with the government paying the costs of the insurance or health plan coverage and the dependent the first $25 of the hospital bill. The Secretary of Defense, however, could limit or deny such private care in areas where he determines that military medical facilities are adequate to handle the service families.

NOTES:

Some of the pharmaceutical houses have told Secretary Folsom that they plan to use more personnel and equipment to step up production of Salk vaccine, but his expectation still is that it will be "many months" before there will be enough vaccine for three shots for "all who need them."

A new suggestion for helping to pay for medical care comes from Rep. Charles S. Gubser (R., Calif.) He is proposing that full income tax deductions be allowed for all medical expenses of children under six years of age.



HE NEEDS AN ORGANOMERCURIAL

In those patients with borderline or very mild congestive heart failure who can even get along without diuretic therapy, any agent producing minimal or intermittent diuresis may appear to produce benefit.

But when cardiac decompensation—mild, moderate, or severe—is established, dependable and continuously effective diuresis—obtainable only with potent oral organomercurials—is a therapeutic necessity.

TABLET
NEOHYDRIN®
BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure

MERCUHYDRIN® SODIUM
BRAND OF MERALLURIDE INJECTION

LAKESIDE

99456

What makes Viceroy different from other filter cigarettes?



The VICEROY filter tip contains 20,000 tiny filters made exclusively from pure cellulose . . . soft, snow-white, natural. This is twice as many filters as the other two largest-selling filter brands.

That is why VICEROY gives you such a fresh, clean taste—that real tobacco taste you miss in other filter brands. No wonder so many doctors now smoke and recommend King-Size VICEROYS.

If it's Viceroy you can tell the difference blindfolded!



King-Size Filter Tip **VICEROY**

New
Evidence
on

Rauwiloid®

confirms and defines superiority over other Rauwolfia preparations in the treatment of HYPERTENSION

- Rauwiloid represents the balanced, mutually potentiated actions[1] of several Rauwolfia alkaloids, of which reserpine and the equally antihypertensive rescinnamine have been isolated.
- Hence, reserpine is not the total active antihypertensive principle of the rauwolfia plant.
- Rauwiloid is freed of the undesirable alkaloids of the whole rauwolfia root. Recent investigations confirm the desirability of Rauwiloid (because of the balanced action of its contained alkaloids) over single alkaloidal preparations; "...mental depression...was...less frequent with alseroxylon..."[2]

The dose-response curve of Rauwiloid is flat, and its dosage is uncomplicated and easy to prescribe...merely two 2 mg. tablets at bedtime.

1. Cronheim, G., and Toekes, I. M.; Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

Riker
LOS ANGELES

Rauwiloid is the original alseroxylon fraction of India-grown Rauwolfia serpentina, Benth., a Riker research development.

Adequate Hospitalization for Treatment of Alcoholics

Doctors find the modern facilities and specialized care available at White Cross Hospital meet a vital need.

Affords Sympathetic Atmosphere, Encouraging Personal Attention, Specially Trained Staff

It is generally believed that alcoholism is self-imposed. Often in general hospitals the alcoholic patient is not considered to be "legitimately" sick, which results in the wrong psychological and emotional atmosphere that aggravates the condition. This is why more and more doctors with alcoholic cases where hospitalization is essential are utilizing the facilities at White Cross Hospital, devoted to the treatment of alcoholics exclusively. Here a sympathetic, comfortable and pleasant atmosphere—so essential to rehabilitation—is assured. The White Cross staff, trained in the special problems of the inebriate, is adequate to assure prompt attention at all hours. The White Cross Hospital is under the direction of a competent licensed physician, with five consulting physicians subject to call. Registered nurses and technicians are in charge 24 hours daily.

Safe, Effective White Cross Treatment

A private hospital offering scientific, institutional, medical, psychological, reflex, reduction and other methods for the rehabilitation of consent patients suffering from alcoholism. With the consent of the doctor and patient, the regular White Cross procedure is followed. At your request, your patient remains entirely under your supervision. You may come and go in White Cross Hospital at will, and will find the staff completely cooperative. Your recommendations will be followed to the letter.

All equipment modern with facilities to take care of 50 patients both male and female.



Salem, Va. Hospital

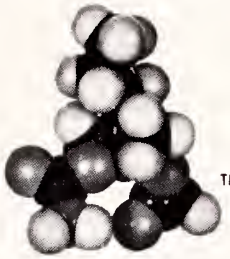
Approved and licensed by the Virginia State Hospital Board, Member American Hospital Association. Located atop beautiful Mt. Regis, in the quiet serene mountains of Virginia—conducive to rest, comfort and rehabilitation.

For information phone or write for booklet
Rates Reasonable

WHITE CROSS HOSPITAL

Five miles west of Roanoke on route No. 11
Salem, Virginia—Phone Salem 4761

Copyright 1955 H.N. Alford, Atlanta, Ga.



THE MILTOWN MOLECULE

Two articles in the April 30th issue of The Journal of the AMA[1,2] report on . . .

an entirely new type of tranquilizer with muscle relaxant action—orally effective in

ANXIETY, TENSION and MENTAL STRESS

- no autonomic side effects—well tolerated
- selectively affects the thalamus
- not related to reserpine or other tranquilizers
- not habit forming, effective within 30 minutes for a period of 6 hours
- supplied in 400 mg. tablets. Usual dose: 1 or 2 tablets—3 times a day

1. Selling, L. S.: J.A.M.A. 157: 1594, 1955. 2. Borrus, J. C.: J.A.M.A. 157: 1596, 1955.

Miltown®

the original meprobamate—2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate—U. S. Patent 2,724,720

DISCOVERED AND INTRODUCED by Wallace Laboratories, New Brunswick, N. J.

Literature and Samples Available On Request

SUDDENLY IT'S SPRING!

Why Not Spruce Up Your Office This Spring With A New Hamilton Suite From CROCKER-FELS?



If you're looking for an unusually attractive examining room suite, unusually servicable equipment, and special features to make your work easier—you'll find them in Hamilton's Steeltone, shown above. And it's available in an array of decorators' colors: white deluxe, cream white, jade green, washington blue, coral, and silver metallic.

The name Hamilton is synonymous with quality.

The Crocker-Fels Company

624 S. THIRD ST. CLay 8855 LOUISVILLE, KY.

Ask about our liberal financing plan

Relax the best way ... pause for Coke



continuous quality is quality you trust

DRINK Coca-Cola REG. U.S. PAT. OFF.

Upjohn

Ulcer protection that lasts all night:

Pamine* BROMIDE

Tablets

Each tablet contains:
Methscopolamine bromide ..... 2.5 mg.

Average dosage (ulcer):
One tablet one-half hour before meals, and 1 to 2 tablets at bedtime.

Supplied: Bottles of 100 and 500 tablets

Syrup

Each 5 cc. (approx. 1 tsp.) contains:
Methscopolamine bromide ..... 1.25 mg.

Dosage:
1 to 2 teaspoonfuls three or four times daily.

Supplied: Bottles of 4 fluidounces

Sterile Solution

Each cc. contains:
Methscopolamine bromide ..... 1 mg.

Dosage:
0.25 to 1.0 mg. (¼ to 1 cc.), at intervals of 6 to 8 hours, subcutaneously or intramuscularly.

Supplied: Vials of 1 cc.

*TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF METHSCOPOLAMINE

The Upjohn Company, Kalamazoo, Michigan

prevents postpartum hemorrhage
speeds uterine involution



'Ergotrate Maleate'

(ERGONOVINE MALEATE, LILLY)

. . . produces rapid and sustained contraction of the postpartum uterus

'Ergotrate Maleate' almost completely eliminates the incidence of postpartum hemorrhage due to uterine atony. Administered during the puerperium, 'Ergotrate Maleate' increases the rate, extent, and regularity of uterine involution; decreases the amount and sanguineous character of the lochia; and decreases puerperal morbidity due to uterine infection.

Supplied:

Ampoules of 0.2 mg. in 1 cc.
Tablets of 0.2 mg.

DOSAGE: Generally, 0.2 to 0.4 mg. I.V. or I.M. immediately following delivery of placenta. Thereafter, 0.2 to 0.4 mg. three or four times daily for two weeks.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

659002

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHTY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 APRIL, 1956 NO. 4

Gastric Ulcer—Criteria for Determining Method of Treatment*

HAROLD J. KULLMAN, M.D., F.A.C.P.**

Dearborn, Michigan

I should like to discuss the criteria for selection of gastric ulcers for medical or surgical treatment. The experimental, clinical and histologic evidence of malignant degeneration of a benign gastric ulcer is infrequent and, if a gastric ulcer is found to be malignant, it probably was a carcinoma at its inception. The danger of malignant transformation of a benign gastric ulcer is not an indication per se for surgical intervention. There are some, mostly surgeons, who believe that differentiation is so unreliable that all patients with gastric ulcer should be submitted to gastric resection.

It is frequently stated that the surgeon and also the pathologist cannot make the diagnosis when palpating and inspecting the gastric ulcer grossly. Many surgeons also feel that the penalty of temporizing with malignant ulcer is greater than that of operating upon benign gastric ulcers. Sufficient data is not available to either affirm or deny this contention.

There is no question that the five year survival rate of all gastric carcinomas has improved since Livingston and Pack reported on an extensive survey conducted in 1939, when it was less than two per cent. Per cent of resectability has also improved. Careful observation, frequent x-ray followups, and not procrastinating with failure to heal or improve in three to six weeks should further improve our statistics as time goes on.

*Presented at the 1955 KSMA Annual Meeting, Sept. 27-29, in Louisville.

**Section Chief, Gastroenterology, Veterans Administration Hospital, Dearborn, Mich. Professor of Clinical Medicine, Wayne University College of Medicine, Detroit, Mich. Consultant, Wayne County General Hospital, Eloise, Michigan.

Therapeutic Test

(a) Relief of all symptoms by medical program, preferably in a hospital;

(b) Complete disappearance of occult blood in stool;

(c) Complete disappearance or marked evidence of healing radiologically in three to six weeks;

(d) Gastroscopic evidence of healing.

In a total of 651 cases treated medically by several groups (including Smith and Jordan, Allen and Welch, and Judd and Priestly), 42 or 6.5% were found to have carcinoma. The chance of 6.5% of carefully diagnosed gastric ulcers being malignant must be weighed against the five per cent mortality and five per cent morbidity of gastric resection for benign ulcer. Smith and Jordan[10] found a higher incidence of carcinoma in recurrent gastric ulcer, namely 15% out of 82 in this group.

Ideally, gastric ulcers which are benign and uncomplicated should be treated by conservative measures, and surgery should be reserved for the malignant ulcers and the complicated gastric ulcers. But with the uncertainty of differential diagnosis, frequent surgical therapy can be neither condemned nor supported; a continued search must be made for criteria which will more accurately diagnose a gastric ulcer as benign or malignant. We should use all facilities available, preferably in a hospital, to arrive at an early decision about surgical treatment, either immediately or after four to six weeks of medical treatment, when repeat studies should help us to decide. Our methods should be designed to detect the earliest signs and suggestion of malignancy and,

also, those benign ulcers which are not going to heal completely on medical management.

Kiefer[4], in discussing only "crater" lesions of the lesser curvature or posterior wall and excluding all frank tumors or infiltrative lesions, concludes that there is cause for "stock taking" and evaluation of experience with gastric ulcer. He quotes the incidence reported by Smith, Boles and Jordan in 1,000 "crater" lesions: 912 were benign and 88 were malignant ulcers. For the individual with a crater in his stomach, the odds are heavily in favor of benign ulcer but there remains an important possibility, that is 8.8% or one in 11½ chances, that the lesion may be an early cancer.

There are many reports which show that subjective data concerning age and sex of the patient, character and duration of symptoms, loss of appetite, weight loss, blood loss and anemia, and the level of free acid in the gastric juice are of little value in making a precise diagnosis. The differential diagnosis depends, therefore, upon repeated objective observation by means of fluoroscopy, radiography, gastroscopy and exfoliative cytology. Recently it has been hinted that studies of mucoprotein and mucoproteose secretion in gastric carcinoma may attain diagnostic levels; this possibility bears further study and reporting.

It is unfair to expect the radiologist to make a final diagnosis at the first examination. There are some pathognomonic or at least highly suggestive signs of malignancy, but practically no pathognomonic signs of benignancy. If the crater is wedge shaped, if it does not penetrate beyond the normal outline of the stomach, or if it is surrounded by a meniscus or flattened mucosal folds, it is highly probable the ulcer is malignant. If the crater is small, flask shaped, penetrates well beyond the lesser curvature line and is surrounded by radiating mucosal folds, the radiologist can be fairly certain of its benignancy. In spite of these signs, there remains an element of possible error.

The one criterion upon which gastroenterologists have come to rely is healing and the disappearance of the lesion during a trial period of ulcer treatment, which includes bed rest, soft diet and neutralization of gastric acidity.

Gastroscopy should be considered a supplementary and not a competitive examination. Therefore, it is probably safer to consider gastroscopic appearance as additional but inconclusive evidence. One of the greatest values a gastroscope possesses is its use in following the complete healing of a gastric ulcer after all radiologic evidences of healing have disappeared.

Medical Treatment—How Long?

Most small ulcers heal in three weeks under medical treatment. Larger ulcers up to two cm. take longer, but in three weeks should show marked improvement. At the Lahey Clinic, if marked shrinking in size or complete disappearance does not occur in 4 to 6 weeks, medical treatment is abandoned for surgical resection. It is true that other clinics believe this is too short, as some ulcers take two to three months to completely heal. At the Lahey Clinic the criteria used probably lean to the radical side as compared to others, but they are far from operating on all ulcers of the stomach.

Of the 1,000 cases reported by Smith, Boles and Jordan, 57.8% came to surgery. 40% of 578 patients were operated upon because certain features of the original examination were suspicious of malignancy, so that any delay seemed unwarranted. Included in this 40% were large, deep lesions which had perforated locally through all layers of the stomach wall to involve adjacent pancreas and liver. These, in my experience, do poorly on medical management and invariably end up having surgery. Another 21% came to surgery because medical criteria failed to satisfy. 16% were recurrent gastric ulcers, where incidence of malignancy increases. 23%—hemorrhage, perforation or obstruction.

The Role of Gastroscopy

X-ray remains safer and simpler for the patient. Gastroscopy is only a supplement to radiology and at no time a substitute for it.

Its greatest value is in following to complete healing of a gastric ulcer. Shallow craters may be seen, as well as erosions which never penetrate below the muscularis mucosa. Bleeding which is unexplained by x-ray should be inspected with the gastroscope. Meadows and Lefeber[6] examined 111 patients with unexplained gastric bleeding and observed chronic gastritis in 33%, gastric carcinoma in three per cent, benign ulcer in four per cent and postoperative stomach in six per cent. There are limitations to gastroscopy, as there are three "blind spots" better observed by the radiologist.

Baker and associates[2] in 1953 reported 11.2% of benign gastric ulcers incorrectly diagnosed as carcinoma. Misinterpretation was occasioned by surrounding nodular gastritis, absent peristalsis, lumenal distortion and necrotic ulcer base.

Schindler and Desneux[8], discussing gastroscopic diagnosis of gastric ulcer, found that, in 273 cases where gastroscopic diagnosis could be verified, 239 were correctly identified. Of these, 191 were benign ulcers and 48 malignant ulcers. A wrong diagnosis was made in 20 cases (18 benign ulcers considered malignant and two malignant ulcers considered benign). The authors conclude that the percent of correct gastroscopic diagnoses is so high that it appears to be the most valuable method in the diagnosis of gastric ulcer.

Gastroscopically, benign ulcers are sharply margined with a clean white or yellowish base, without rigidity, nodularity or irregularity. Effaceability of gastric rugae by inflation is characteristic and helps to differentiate the benign from the immobile carcinomatous lesion. A carcinomatous ulcer usually exhibits a necrotic base of many colors, sometimes bleeds eccentrically, and has overhanging margins that are often steep, nodular, irregular and rigid. Adjacent mucosa is frequently rigid and nonresponsive to air inflation.

In the past five years Papanicolaou and Cooper and others have stimulated cytologic studies. A great problem here is the obtaining of satisfactory specimens. The abrasive balloon, and more recently gastric brushing, described by Ayre and Oren[1] in 1953, have been employed.

Malignant cells tend to separate from parent tissues more readily than normal tissue cells because of low calcium content, lack of adhesiveness, susceptibility to mechanical trauma and greater friability and necrosis of tissue whose growth has exceeded the blood supply.

In 56 cases having gastric brushing before going to surgery, Browne, Mitchell, Welch and Sorrell[3] found that, of 17 having a pathologic diagnosis of malignant ulcer, only four were positive for malignancy and six compatible with malignancy, thus leaving seven with negative gastric brushings.

Relation of Gastric Ulcer to Carcinoma of Stomach

Absolute positive evidence that gastric ulcer may become malignant or undergo malignant degeneration is difficult to prove histologically. Shields Warren states that, in the resected specimens from the Lahey Clinic, there have been only four in which there was evidence that cancer probably arose on the basis of pre-existent benign gastric ulcer. Only when there is existence of long standing destruction and fibrosis of the stomach wall can one be suspicious of cancer developing on a chronic gastric ulcer.

Palmer[7] pointed out that there are many pathognomonic signs of malignant disease in an ulcerating gastric lesion, but there are no pathognomonic criteria that the ulcer is benign.

Marshall[5] states that the routine surgical treatment of all cases of uncomplicated gastric ulcer is not recommended and is undesirable; in a considerable number of cases, it cannot be regarded as a prophylactic measure against the development of carcinoma of the stomach. I do not advocate or advise immediate operation in every case of gastric ulcer but it is my opinion, and that of others, that a higher percentage, probably fifty per cent or more of chronic gastric ulcers, should be resected, since an appreciable number have been found at operation to be malignant. Temporizing with a non-healing, ulcerating lesion involves serious risk to the patient and is completely unjustified.

Smith and Jordan noted complete healing in 84 of 145 patients in 4 weeks, and in 52 of the remaining within five to eight weeks.

At the Gastrointestinal Cancer Symposium of November 19, 1954 Shields Warren, speaking on the pathogenesis of gastric cancer, concluded that cancer almost never develops in a healthy mucosa. In discussion, A. P. Stout pointed out that there may be different sorts of cancer associated with achlorhydria and with ulcer, but he does not believe that there is a general relationship between cancer and ulcer. Attempts to determine degree of clinical malignancy from histological examination he found frustrating.

Summary

The most difficult problem for the physician confronted with a gastric "crater" lesion is the differentiation of malignancy from benignancy at the time of examination.

There is still a place for the medical treatment of benign gastric ulcer but, with the uncertainty of differential diagnosis, frequent surgical therapy can be neither condemned nor supported. A con-

tinued search must be made for criteria which will more accurately diagnose a gastric ulcer as benign or malignant.

Clinical criteria, such as size of ulcer, location of lesion, age of the patient and history, are not completely reliable and, if malignancy cannot be excluded by all methods of examination including a therapeutic trial, surgical intervention is an absolute necessity.

The routine surgical treatment of all gastric ulcers is not recommended and is undesirable. It cannot be recommended as a prophylactic measure against cancer developing in the stomach.

Roentgenography, with its increasing refinements and improved technique, has contributed significantly but still leaves much to be hoped for in early diagnosis of carcinoma of the stomach, when removal would effect a cure. In recent years, gastroscopic examination, with or without biopsy, has improved the accuracy of early diagnosis but its limitations are well established. Cytologic studies may be helpful, but one cannot depend on a negative report.

BIBLIOGRAPHY

1. Ayre, J. E. and Oren, B. G.: A New Rapid Method for Stomach Cancer Diagnosis: The Gastric Brush. Cancer, 6: 1177, 1953.

2. Baker, L., Gorvett, E. A. and Spellberg, M. A.: Diagnostic Accuracy of Gastroscopy in Neoplasms of the Stomach. Cancer 5: 1116, November 1953.

3. Browne, D. C., Mitchell, R., Welch, G., and Sorrell, W.: Evaluation of Gastric Exfoliative Cytology. Gastroenterology, 28:964, June 1955.

4. Kiefer, E. D.: Gastric Ulcer—Which Ulcers Should be Operated Upon. Lahey Clinic Bulletin, 9:101, April 1955.

5. Marshall, S. F.: Relation of Gastric Ulcer to Carcinoma of Stomach. Annals of Surgery, 137:891, June 1953.

6. Meadows, J. C. and Lefeber, E. J.: Gastroscopy, 14 year Surgery, 1000 Consecutive Examinations. Annals of Internal Medicine, 42:69, January 1955.

7. Palmer, W. L.: Differential Diagnosis between Benign and Malignant Gastric Ulcer. In: Sandweiss, D. J.: Peptic Ulcer. Philadelphia, W. B. Saunders Co., 1951, pages 269-274.

8. Schindler, R. and Desneux, J.: Gastroscopic Diagnosis in 273 Gastric Ulcers. Gastroenterology, 24: 328, July 1953.

9. Smith, F. H., Boles, R. S., Jr., and Jordan, S. M: The Problem of Gastric Ulcer Reviewed. J.A.M.A. 153:1505, Dec. 26, 1953.

10. Smith, F. H. and Jordan, S. M.: Gastric Ulcer, A Study of 600 Cases. Gastroenterology, 11:575, 1948.

Office Management of Conductive Deafness*

EUGENE L. DERLACKI, M. D.

Chicago, Illinois

The management of any case of hearing loss is based upon an accurate and complete otologic diagnosis, which includes the type, the degree and the etiology of the loss. The type diagnosis, as a rule, determines whether medical treatment is to be considered. Except in a labyrinthine hydrops, a diagnosis of pure perceptive deafness precludes any medical restoration of practical hearing and indicates need for audiologic rehabilitation. In contrast, diagnosis of a conductive deafness offers the possibility of substantial improvement by medical or surgical treatment.

Type Diagnosis

Our own feeling is that the masked Rinne and Schwabach tuning fork tests are still needed in making a type diagnosis, even though improved audiometry is now quite reliable. In audiometry the air-bone gap is the differentiating characteristic which establishes either a conductive loss or a perceptive loss with or without a superimposed conductive component.

The pure perceptive loss is characterized by an interweaving air and bone audiogram (no air-bone gap) confirmed by classical tuning fork results of a positive Rinne and a shortened Schwabach. A consistent air-bone gap of 20 decibels or more means a lesion of the sound conducting system, the size of the gap being a measure of the degree of the obstruction to sound conduction, while the loss by bone measures the perceptive component.

The negative Rinne test and normal or prolonged Schwabach, with an air-bone gap in the audiogram, determines a conductive hearing lesion and its exact etiologic diagnosis is made from the history and examination of the ear, nose and throat. This is relatively easy since there are only six main causes for conduction deafness:

1. Occlusion of the external auditory meatus, which can be acquired (cerumen, external otitis) or congenital (fibrous or bony atresia.)

2. Perforation of the tympanic membrane.

3. Occlusion of the eustachian tube and/or secretory otitis media.

4. Suppurative otitis media, acute and chronic.

*Presented at the 1955 KSMA Annual Meeting, Sept. 27-29, in Louisville.

5. Chronic adhesive otitis (the end result of previous suppuration).

6. Otosclerosis, and congenital ossicular malformations causing impaired function of ossicular chain.

Prognostication

After the diagnosis of a conductive hearing impairment has been made, proper office management includes all the therapeutic and rehabilitative medical measures in our armamentarium of office procedures as well as the proper selection of cases for various surgical procedures available for the preservation or restoration of practical hearing. There is a considerable difference of opinion concerning the possibilities of medical therapy of deafness. Canfield's[1] pessimistic view in a 1948 statement that "not more than 10% of those whose hearing is impaired can expect unaided improvement in hearing" is in sharp contrast to Shambaugh's[2] statement that "roughly 40% of patients seen in one year in an otologic practice had a hearing loss that could be improved substantially by medical therapy." These variable estimates are naturally based on the treatment potential in conductive deafness and my own experience just as naturally favors the more optimistic view of Shambaugh. The percentage of success in treatment should be appreciably higher in children than in adults, since one sees many more reversible conductive lesions in children compared to the more frequent irreversible end-results of these lesions in adults.

In our own experience the principal conductive lesion we see in our adult practice is clinical otosclerosis whereas in children chronic or recurrent occlusion of the eustachian tube and/or secretory otitis media is the most frequent cause of conductive deafness. Much has been written on the subject of chronic secretory otitis media as a troublesome therapeutic problem. The more attention focussed on secretory otitis the better, since our experience agrees with that of Hoople[3] in finding that secretory otitis is a frequently overlooked cause of impaired hearing in all age groups. Since the definitive care of secretory otitis falls under office care more than otosclerosis does, I will discuss my management of these cases first.

Secretory Otitis

In several yearly reviews of the cases of tubal occlusion and secretory otitis media seen in a private otologic practice by three otologists (G. E. Shambaugh, Jr., M. D., W. H. Harrison, M. D., and the author) I have found a variable audiometric picture which I feel reflects the pathogenetic mechanism in each case and also may lead to a more logical therapeutic approach.

Secretory otitis media with the middle ear completely filled, or nearly so, with fluid produced either a relatively flat or a downward sloping (high tones depressed) air conduction audiogram. In some of the downward sloping audiograms the low tones can be at or near normal level. In contrast the cases of eustachian tube occlusion with no fluid or with only a barely perceptible fluid level along the lower drum margin usually show an upward sloping audiogram with emphasis upon the low tone loss. To us this is further clinical confirmation of Campbell's[4] interesting and informative paper in 1949 which brought to the attention of American otologists the "differential diagnostic implications of the portions of the (impedance) formula which have to do with stiffness and mass."

The histology of the upper respiratory tract, eustachian tube and middle ear is an imporant consideration in the concept of the histopathologic changes which can occur to produce a varying degree of tubal occlusion and secretory otitis media. The respiratory membrane of the nose (similar to that of the trachea and bronchi) the nasopharynx, the adenoid lymphoid structures and the eustachian tube, which is phylogenetically and embryologically a diverticulum from the nasopharynx, is made up of tall columnar epithelial cells capped by cilia and is often termed "pseudostratified ciliated epithelium." Between the columnar cells and probably identical with them, are the mucin containing goblet cells which are one source of mucus. In the subepithelium, or tunica propria, are the seromucinous glands which predominate in certain portions of the respiratory tract and are the other source of the mucous coating of the epithelium. Certain irritating stimuli increase the production of mucus not only from the seromucinous glands but from the more active and greater number of goblet cells as well.

In its normal state the epithelial lining of the middle ear consists of simple nonciliated cuboidal cells with relatively little submucosal connective tissue. However, this epithelium has an inherent capacity for changes, under apparently slight stimulus, which produce a lining

membrane not unlike respiratory epithelium in appearance and behavior.

Tubal Occlusion

Occlusion of the eustachian tube is due chiefly to the inflammatory changes in the respiratory epithelium and adenoid lymphoid structures of the nasopharynx and in the tubal epithelium. The inflammation may be infectious or allergic in nature. Whether the tubal occlusion is complicated by serous fluid in the middle ear depends somewhat upon the degree and duration of the occlusion. As stated previously, a tubal occlusion depresses the low tones causing an upward sloping air conduction audiogram through "the splinting effect of unequal pressure on the two sides of the tympanic membrane" causing an "increase in the stiffness of elements of the conduction system." When a complicating serous effusion occurs in the middle ear (the mechanism of this effusion has been described by many writers) the audiogram is flattened or humped because the "mass of elements of the conduction system" imposes an additive high-tone depression. In a child whose nasopharyngeal examination reveals a large adenoid or adenoid remnant which may appear to be producing a mechanical obstruction by its very size, it may be very difficult to evaluate whether this is the sole cause of the tubal dysfunction or whether there is the additional factor of occlusion from inflammatory swelling of the tubal mucosa. I feel that the latter cause may often be the more important one in producing the obstruction to normal ventilation of the middle ear. The clinical examination in a case of tubal obstruction with secretory otitis media reveals a retracted drum membrane with fluid in the middle ear, and in long-standing or frequently recurrent cases there may be considerable attic retraction.

The third main cause for conduction deafness was purposely listed as occlusion of the eustachian tube and/or secretory otitis media. There are a considerable number of cases in whom a secretory otitis media produces a downward sloping curve in the audiogram with depression of the high tones and near normal hearing for the lower frequencies. The otoscopic picture here again reveals fluid in the middle ear, but there is absence of retraction of the pars tensa or flaccida, in fact the pars tensa may be even bulging. Both the audiogram and the otoscopic picture speak for an increase of the mass of elements of the conduction system by fluid in the middle ear with little or no tubal occlusion which would increase the stiffness factor. Moreover, politzer inflation is easily accomplished with low pressure. These cases reflect, in my opinion, the change in the middle ear mucosa described by Eggston and Wolff[5] from a cuboidal to a columnar epithelium with goblet cells which is reacting to an allergic or vasomotor stimulus. A lack of normal thyroid activity may be an occasional factor.

Variable Involvement

The author has postulated a variable involvement of the upper respiratory tract, the eustachian tube and the middle ear in the past[6(a)] and still feels that this is a reasonable hypothesis. We see many cases of seasonal and perennial respiratory allergy in which the principal allergic inflammation involves the nasal mucosa with little or no apparent involvement of the tracheo-bronchial tree and vice versa, so why should there not also be a selective greater involvement of the respiratory epithelium of the eustachian tube or of the metaplastic respiratory-like mucosa of the middle ear? Many cases of eustachian tube occlusion and/or secretory otitis media also have chronic nasal allergy, which is in keeping with the finding in allergic individuals that multiple clinical manifestations of allergy are the rule rather than the exception. I have no doubt that many otolaryngologists will question the diagnosis of nasal or aural allergy. This is justifiable since there is no single accepted conclusive test to prove an allergy. Certainly reliance upon skin testing is misleading and disappointing in an allergic search. To an otolaryngologist who makes his own allergic diagnostic studies and carries out his own allergic management "the most reliable proof of an allergic etiology and of a specific allergen is the therapeutic test: the relief of symptoms by removal of a substance or by treatment with an extract of the substance, and the recurrence of symptoms upon re-exposure to the substance or upon stopping treatment."[6(b)]

The Basis For Treatment

The foregoing concept of pathogenesis of eustachian tube dysfunction and secretory otitis media is the basis for treatment. The history of the onset and the course of the conduction deafness can often add considerable information to the otological and audiological picture at the

time of initial examination. If the child has enlarged adenoid and tonsils and a history and findings of a recurring conductive hearing loss due to secretory otitis media during and following each episode of acute nasopharyngitis and tonsillitis then an adeno-tonsillectomy is advised. If, on the other hand, a child is seen with adenoid hypertrophy and a secretory otitis media in which the conduction deafness fluctuates seasonally or perennially, especially when coexistent with a similarly fluctuating nasal allergy, then it it felt that the respiratory allergy should be controlled first by specific allergic management and, then only, the adenoid is considered for surgical removal if there is still an appreciable tubal obstruction.

Many such cases are so well controlled by allergic management that adeno-tonsillectomy is never done or only carried out later for another legitimate indication. Another benefit from delaying adenoidectomy until a respiratory allergy is thoroughly controlled is the feeling I have that there is a marked tendency for partial or complete prevention of adenoid regrowth following removal which is so common in the allergic child. The most extreme cases in which there can be little doubt of the need of searching for an underlying allergy are those cases of secretory otitis media presenting the high tone loss on audiogram, whose nasopharynx has been rendered as devoid of lymphoid tissue as is possible by surgery and radiation and who have already had numerous inflations and paracenteses. The same philosophy of treatment applies to adults, although the adenoid mass is seldom as large as in children, and adenoidectomy is less often considered.

Otitis Media

Acute suppurative otitis media in the modern antibiotic era is a relatively self-limited cause for conduction deafness. Chronic suppurative otitis media can be a cause of permanent and progressive conduction deafness, and often requires a prolonged plan of medical care for eventual hearing restoration.

The benign chronic otitis media with a central perforation may be due only to a superficial specific infection of the mucosa of the middle ear and eustachian tube, or it may be complicated by the same etiologic factors discussed under tubal occlusion and secretory otitis media.

The treatment of the benign type of chronic suppurative otitis media consists of careful cleaning of the middle ear, tubal inflation to clean the eustachian tube and a choice of many powders to be insufflated or drops to be used by the patient. The ideal method of selecting an antibiotic for local use is through sensitivity titration against the cultured organism. In the cases of allergic chronic suppurative otitis media this conservative management will often fail or be only temporarily effective unless proper specific allergic management is carried out.

Once a dry central perforation of the tympanic membrane has been obtained with proper therapy there is at least a 70% chance of healing the perforation by closure treatment as described by the author[7] in 1953. If repeated infections have not resulted in too advanced a chronic adhesive otitis, closure of the perforation can result in a very useful restoration of hearing, at times approaching normal levels. If a trial on closure treatments is unsuccessful, or if for reasons of economics or distance the patient cannot undergo a closure trial, then the use of middle ear or tympanic prosthesis should certainly not be overlooked.

The prostheses we have had the most successful results with are the cigarette paper patch, the Way drum, the Korogel insert popularized by Pohlman[8], and the use of a wax such as aquaphor, hydrosorb or beeswax whose effectiveness has been so eloquently described by Kobrak[9]. The paper patch and the wax prosthesis must be reapplied by the otologist at regular intervals, whereas the Way drum and Korogel insert have the advantage of being easily removed and inserted by the patient. The latter two as well as the wax prosthetic can be used to seal a relatively small perforation or be applied directly to the medial wall of the middle ear after testing for the so-called "hot-spot" with an acoustic probe. The patch prosthesis needs a reasonable rim of pars tensa around the perforation for easy, painless application and for a long enough period of improved hearing before the patch migrates away from the perforation with the epithelial migration.

Chronic suppurative otitis media of the bone invading type with either a primary or secondary acquired cholesteatoma presents more of a problem in medical restoration of hearing. The secondary acquired cholesteatoma which follows acute necrotic otitis media may have produced such a destruction of the conductive mechanism as to prevent any improvement

in hearing and then eradication of the chance of intracranial extension of infection becomes the only reason for proper medical or surgical care.

Although the ossicular chain can be destroyed to varying degrees in both primary and secondary cholesteatoma, the hearing in the former type is likely to be affected to a less severe degree than in the latter case. I agree with Jordan[10] that chronic adhesive otitis and primary acquired cholesteatoma are the all too frequent sequelae of chronic tubal dysfunction and recurrent secretory and suppurative otitis media, and that there is a reasonable expectation of preventing these cases by proper management as previously outlined under the treatment of secretory otitis media. Juers[11,12] has some excellent diagrammatic sketches of the role of chronic negative intratympanic pressure in the gradual development of primary acquired cholesteatoma. Once a cholesteatoma is present and infected our philosophy of treatment is to remove the retention products, the mass of desquamated skin. This is done either by attic irrigation or, when conservative management fails, by exteriorizing the cholesteatoma by a modified mastoidectomy, using such procedures as Juers[12] myringo-stapediopexy whenever possible to preserve or restore a serviceable level of hearing.

Reconstructive Surgery

A conduction deafness produced by occlusion of the external auditory canal by cerumen or by stenosis of the canal from severe external otitis media needs no discussion. However, when a chronic external otitis resists therapy it may result in a thin epithelial web or a thickened fibrous tissue atresia which requires surgical correction to erase the conductive hearing loss. The indications for reconstructive surgery for the correction of congenital atresia and developmental anomalies of the middle ear are still a matter of debate in unilateral cases but there is general agreement that the bilateral cases deserve an attempt at surgical correction. Office management of these cases resolves itself into discussing the advisability of the surgery with the parents, and in attempting to evaluate the cochlear function in a child, since congenital cochlear anomalies may be coexistent and preclude reaching a practical level of hearing by surgical reconstruction. As to advising one operation or a certain surgical technic, Shambaugh and the author have emphasized in their reports[13,14] and their movie on the subject of congenital anomalies of the sound conducting apparatus and their surgical correction that the particular anomaly varies considerably. Thus, no one technic is suitable for all cases and the surgical procedure should be fitted to the condition that is found with an aim to reconstruct the sound conducting system that will most nearly approach the normal inpedance-matching mechanism. At the present writing we have had approximately 50% success in obtaining maintained improvement in hearing up in the practical level above 30 decibels in the speech frequencies. A number of cases have had excellent hearing levels which were not maintained due to secondary fibrosis and fixation of the ossicular chain or stapes and the skin graft. Whether a subsequent fenestration or attempt at revision with removal of adhesions is the proper procedure in these failures has not been settled as yet. There are several details of the handling of skin grafts, split or full thickness, in approximation to a movable stapes or ossicular chain and maintaining a good middle ear space which are certainly not solved.

Otosclerosis and Fenestration

As was mentioned earlier, clinical otosclerosis was the most common cause of conduction deafness in adults seen in our practice. Accurate diagnosis and a reasonably accurate estimate of the cochlear function in each case are certainly the obligations which every otologist has to his patients in order to achieve optimum results from medical management. It has always been a matter of concern that too many cases of otosclerosis suitable for fenestration have been diagnosed as incurable nerve deafness.

The question of selection of cases for fenestration surgery has been discussed by many authors in the past 17 years. Selection of cases for surgery has been greatly simplified now that we can obtain a reasonable estimate of the predicted hearing result from fenestration in an individual case by adding the "unrestored residue of conductive loss" from the operation to a corrected bone audiogram level in the speech frequencies using either the Shambaugh[15] or the Davis and Walsh[16] methods. This level to be expected from surgery in 70 to 80% of "A" cases can be compared to the speech reception thresholds obtained with the hearing aid on the same ear. On the basis of speech tests made with

the patient's hearing aid before surgery, and without the aid after operation, we have found that on the average in "A" cases ideally suited for operation fenestration provides slightly superior hearing to a hearing aid.

Now in the past year particularly, the transtympanic stapes mobilization operation of Rosen has made selection of cases for surgery more complicated. The indications for fenestration surgery remain unchanged, but no exact indications have emerged as yet for the stapes mobilization. Rosen's[17] and Scheer's[18] published reports seem to use the diagnosis of clinical otosclerosis as the indication for the mobilization procedure. Obviously, the cochlear function will provide the ceiling to be obtained in the hearing level from the operation in a given case, but whether the air-bone gap will be completely eradicated in every successful stapes mobilization remains to be seen. To us it would seem reasonable to include not only the level of cochlear reserve, but also the degree of stapes fixation as determined by tuning fork tests correlated with actual findings at surgery, in any eventual system for selection of the ideal cases for the new operative procedure. Another question which we feel will need to be answered is whether cases in which the otosclerotic focus is in an active period of growth will tend to re-fix the stapes rapidly even if it is successfully mobilized. My own feeling, based upon too short an experience, is that the optimum results will be obtained by the stapes mobilization operation in those cases who have been at a stable level for several years with a "burned out" otosclerotic focus which is producing less than complete stapes fixation. I would expect that partial stapes fixation would offer more chance of successful fracture around the footplate (realizing that the size and strength of the crura also influence this chance profoundly) with a better likelihood of eliminating the air-bone gap.

A last word is in order concerning chronic adhesive otitis as a cause of conductive deafness. Many of these cases show partial to complete ossicular or stapes fixation with an intact, but often very scarred, tympanic membrane, and can be evaluated for suitability for fenestration surgery exactly the same as a case of clinical otosclerosis would be evaluated with the individual audiogram.

Conclusion

In conclusion, I believe that modern otology offers the hard of hearing patient with a conductive deafness more chance for substantial improvement to a practical level of hearing by thorough office management and by the proper selection of cases for surgery than is sometimes appreciated.

The failure to recognize cases of secretory otitis media, to treat a moist or dry central perforation without trying closure or prosthesis treatment, or to diagnose otosclerosis suitable for surgery inaccurately as incurable nerve deafness is an avoidable cause for not achieving the optimum results in the office management of conductive deafness.

REFERENCES

1. Canfield, N.: Audiology, the Science of Hearing, Acta oto-laryng. Supp. 76, 6-16, 1948.

2. Shambaugh, G. E., Jr.: The Management of Deafness, Illinois M. J. 100: 335-337 (Dec.) 1951.

3. Hoople, G. D.: Otitis Media with Effusion: A Challenge to Otolaryngology, Tr. Am. Acad. Ophth. & Otolaryng. 531-541 (May-June) 1950.

4. Campbell, P. A.: Importance of Impedance Formula in Interpretation of Audiograms, Tr. Am. Acad. Ophth, & Otolaryng. 245-252 (Jan.-Feb.) 1950.

5. Eggston, A., and Wolff, D.: Histopathology of the Ear, Nose and Throat, Ed. 1, Baltimore, The Williams & Wilkins Company, 1947.

6. (a) Derlacki, E. L.: Aural Manifestation of Allergy, Ann. Otol. Rhin. & Laryng. 61:179-188 (March) 1952. (b)————, and Shambaugh, G. E., Jr.: Allergic Management of Some Common Ear Conditions, Tr. Am. ACAD. Ophth. & Otolaryng. 304-311 (May-June) 1953.

7. ————: Repair of Central Perforations of Tympanic Membrane, Arch. Otolaryng. 58: 405-420, (Oct.) 1953.

8. Fohlman, M. E.: The Artificial Middle Ear Drum, Ann. West. Med. & Surg. 2:413 (Sept.) 1948.

9. Kobrak, H. G.: Treatment of Deafness by Prosthesis, Ann Otol. Rhin. & Laryng. 61:1053-1066 (Dec.) 1952.

10. Jordan, R. E.: Role of Allergy in Otology, Arch. Otolaryng. 55: 363-366 (March) 1952.

11. Juers, A. L.: Modified Radical Mastoidectomy, Arch. Otolaryng. 57: 245-256 (March) 1953.

12. Juers, A. L.: Preservation of Hearing in Surgery for Chronic Ear Disease, Laryngoscope 64: 235-251 (April) 1954.

13. Shambaugh, G. E., Jr.: Developmental Anomalies of the Sound Conducting Apparatus and Their Surgical Correction, Ann. Otol. Rhin. & Laryng. 61:873-883 (Sept.) 1952.

14. Derlacki, E. L., and Shambaugh, G. E., Jr.: Correction of Congenital Anomalies of the Ear, Illinois M. J. 105:107-109 (March) 1954

15. Shambaugh, G. E., Jr.: Correlation of the Predicted with the Actual Result of Fenestration in 164 Consecutive Cases, Laryngoscope 62: 461-474 (May) 1952.

16. Davis, H., and Walsh, T.: The Limits of Improvement of Hearing Following the Fenestration Operation, Laryngoscope 60: 273-295, 1951.

17. Rosen, S.: Restoration of Hearing in Otosclerosis by Mobilization of the Fixed Stapedial Footplate. An Analysis of Results, Laryngoscope 65:224-258 (April) 1955.

18. Scheer, A.: Restoration of Hearing in Otosclerosis by Transtympanic Mobilization of the Stapes, Arch. Otolaryng. 61:513-534 (May) 1955.

The Closure of Interatrial Septal Defects*

WILLIAM H. MULLER, JR., M. D. **

Charlottesville, Virginia

The interatrial septal defect represents one of the most common congenital cardiovascular deformities and during the past few years, several methods have evolved for its surgical closure.

Types of Defect

The defect may be one of several types. There may be a complete absence of the septum resulting in a single auricle, but there is usually some vestige of a septal rim. A second type occurs when there is an absence or incomplete development of the septum secundum. This is one of the most common types which, fortunately, lends itself to surgical repair most satisfactorily.

A third type occurs when there is failure of development of the septum primum which results in a low defect so that no rim of tissue persists between the mitral and tricuspid valves. Repair of this type of defect presents a greater problem than the septum secundum defect and results are not as satisfactory. A more complex defect is the atrial ventricularis communis in which the lower portion of the auricular septum and the upper portion of the ventricular septum are absent so that there is usually a common valve between the auricles and the ventricles whose central defect allows communication between all four cardiac chambers. Not infrequently, one or more of the pulmonary veins may drain into the right auricle or one of its tributaries when an atrial septal defect is present. The small, uncomplicated septum secundum defect will often present no signs or symptoms until later life. In some instances, although symptoms are not present, frequent respiratory infections occur with retardation in physical development, and examination usually reveals cardiac enlargement, particularly of the right auricle and right ventricle. Electrocardiographic examination will show evidence of right ventricular hypertrophy and occasionally a complete or partial right bundle branch block. If the defect is large, dyspnea may occur. Auscultatory examination of the heart usually shows only a systolic murmur maximal in the region of the pulmonic valve. In the older patient with a large defect, cyanosis may be present either constantly or during exertion.

Hemodynamic alterations consist of the shunting of blood from the left to right auricle. This occurs because the mitral valve is smaller than the tricuspid valve, resulting in a higher filling pressure for the left ventricle. Consequently, a higher pressure in the left auricle results. The pulmonary blood flow greatly exceeds the systemic blood flow and depending on the size of the shunt and the pulmonary resistance, there may be a normal pressure in the pulmonary artery or varying degrees of pulmonary hypertension. The persistence of a high pulmonary blood flow and pressure over a long period of time causes the small pulmonary arteries to become thick-walled and smaller-lumened, and results in an increased pulmonary resistance. If this sequence of events continues, the pressure in the right side of the heart may exceed that in the left side so that the shunt through the septal defect is reversed. At first, reversal may occur only during exertion but later may become persistent. When this happens, cyanosis develops.

Closure Procedures

At present, four procedures are being used to close atrial septal defects. One method is the procedure developed by Gross and associates[1] which employs a rubber funnel-shaped well sutured to an incision in the right auricle. The blood is allowed to rise to the level of right auricular pressure in this well, and one can palpate the defect and suture the edges together or suture a prosthesis over it by working through the column of blood. This procedure has the advantage of allowing one to close the defect by a direct method, but has the disadvantage of being tedious and time-consuming and, although direct, is not a visual procedure and is associated with alterations in hemodynamics while the well is filling, which are undesirable.

A second procedure used successfully by Lewis and Taufic[2], and Swann and associates[3] is the occlusion of venous cardiac inflow during hypothermia and expo-

*Presented before the Ky. Surgical Society Meeting, May 21, 1955 at Hot Springs, Va.

**The Department of Surgery, University of Virginia School of Medicine, Charlottesville, Virginia, and the UCLA Medical Center, Los Angeles, Calif.

sure of the defect through an incision in the auricle. It can then be closed under direct vision. This procedure, ideally, allows one to visualize the defect and close it under direct vision but places a time limit on the surgeon, increases the possibility of air embolism and introduces the added factor of hypothermia.

A third method is the so-called atrio-septo-pexy procedure devised by Bailey and associates.[4] Under digital guidance, the wall of the right auricle is sutured to the rim of the defect. This is a relatively simple procedure but is not applicable to all types of defects.

A fourth procedure is that devised by Bjork and Crafoord[5] which involves the dissection of a groove between the superior vena cava and right auricle and pulmonary veins. Under digital guidance, a long, thin needle is introduced through the right auricular wall close to the origin of the aorta and through the auricular septum and upper portion of the ventricular septum. It is brought out posterior to the inferior vena cava near the annulus fibrosis and the two ends of the sutures are then tied in the groove between the right auricle and the pulmonary veins, thus encircling the defect and constricting its edges so that they come together.

Initially, the Gross atrial well procedure was employed to close the atrial defects in this series.[6] In the last half of the group, however, the atrio-septo-pexy technique was employed when possible because it is simpler and accomplishes a satisfactory closure. The patient is anesthetized with endotracheal anesthesia and placed in the supine position with the right side elevated to approximately 20°. The chest is entered through an antero-lateral incision in the fourth intercostal space and the fourth costal cartilage is usually divided adjacent to the sternum to facilitate exposure. The pericardium is incised longitudinally anterior to the phrenic nerve, extending upward over the area of the right auricular appendage. A pursestring suture is placed about the base of the appendage and the finger is introduced into the right auricle. If feasible, the atrio-septo-pexy procedure is performed, but if not, the Bjork-Crafoord procedure or the atrial well technique is employed. The pericardium is reapproximated loosely so that it may drain adequately. The chest is closed in the routine fashion and water seal drainage is instituted.

Results

A total of 27 patients were operated upon in this series. Of this group, 26 had a septum secundum defect and one had a septum primum defect accompanied by a deformed mitral valve. Three of those with septum secundum defects had partial transposition of the pulmonary veins. No patient was operated upon who did not have symptoms and signs related to the defect. All of them had easy fatigability and nearly all of them had dyspnea on exertion. None were cyanotic. Cardiac catheterization was performed in all but one patient and is considered one of the most valuable diagnostic adjuncts. Nine of the patients had been in cardiac failure and one was in failure at the time of operation. The atrial well technique was used in seventeen and the Bailey atrio-septo-pexy procedure in 10. There were three deaths, all occuring in patients on whom the atrial well procedure was employed One of these was a child of six who had a large septum secundum defect and a deformed mitral valve and had been in severe failure for two years previously. Two others were adults, ages 31 and 36, who had severe pulmonary hypertension. In three patients who had transposition of the right pulmonary veins, the atrio-septo-pexy procedure was used and a pocket was formed into which the veins emptied through the defect into the left side of the heart. In one of these patients, it was necessary to include half the circumference of the superior vena cava for a distance of about three cm. In one patient, an eight year old child who had a septum primum defect and a mitral valve deformity, a nylon plastic prosthesis was sutured to three sides of the defect but could not be sutured inferiorly because no tissue rim was present. Because of the severe heart failure which developed, it was necessary to re-apply the atrial well and remove the plastic patch three weeks later. It was felt that the high left atrial pressure deflected the patch to the right, partially covering the tricuspid valve and producing the cardiac failure. Pericarditis developed in three patients and was relatively low-grade in character. A pericardotomy was performed on one patient whose temperature rose to 103-104° for several days but no frank pus was obtained. All of the patients responded to antibiotic therapy. The remaining patients have all shown clinical improvement. Dyspnea has markedly improved or disappeared and the cardiac

failure no longer occurs in those patients in whom it had been present. The exercise tolerance is usually increased. X-ray examination of the chest showed a diminution in the size of the heart in most patients especially those who had marked cardiac enlargement. Pressures were measured in the cardiac chambers immediately before and after the defect was closed and it was found that the pressure usually fell in the right auricle, right ventricle, and pulmonary artery and rose slightly in the left auricle and aorta. Blood samples obtained from these chambers generally showed a fall in the oxygen saturation of the right auricle, right ventricle, and pulmonary artery, and no change in that of the left auricle or brachial artery. Blood volume determinations by the T-1824 dye method, made shortly before and two weeks after operation, indicated a diminished blood volume when the defect was closed.

Conclusion

Although only those patients who have had symptoms or who have showed progressive cardiac strain have been operated upon previously, it seems entirely likely that in the near future, all patients in whom a diagnosis of atrial septal defect is made will be considered candidates for operation. The physiologic alterations in the hemodynamics are quite similar to those in patent ductus arteriosus in which there is a shunting of blood from the left to the right side of the heart. Because of the complications which can occur, especially in later life, when this deformity is present and because the operative mortality rate is extremely low, most cardiologists and surgeons feel that the diagnosis of patent ductus arteriosus is sufficient indication to recommend operation to those patients. It seems entirely likely that as procedures for the closures of atrial septal defects become more refined, resulting in a low mortality rate, the diagnosis of atrial septal defect will become an indication for its closure.

BIBLIOGRAPHY

1. Gross, R. E., Pomeranz, A. A., Watkins, E., and Goldsmith, E. I.: Surgical Closure of Defects of the Interauricular Septum by Use of an Atrial Well, New England J. Med. 247: 455. 1952.

2. Lewis, F. J., and Taufic, M.: Closure of Atrial Septal Defects with the Aid of Hypothermia, Surgery 33: 52, 1953.

3. Swan, H.: Surgical Closure of Interauricular Septal Defects, J.A.M.A. 151: 792, 1953

4. Bailey, C. P., Bolton, H. E., Jamison, W. L., and Neptune, W. B.: Atrio-Septo-Pexy for Interatrial Septal Defects, J. Thoracic Surg. 26: 184, 1953.

5. Bjork, V. O., and Crafoord, C.: The Surgical Closure of Atrial Septal Defects, J. Thoracic Surg. 26: 300, 1953.

6. Muller, W. H., Smith, S. W., Dammann, J. F., Adams, F. H., and Darsie, M. L.: Considerations and Physiologic Studies in the Closure of Interauricular Septal Defects Surgery 37: 1, January, 1955.

The Role of The Medical Department in Today's Navy*

O. B. MORRISON, JR.

REAR ADMIRAL, MC, USN

Portsmouth, Virginia

I will try to tell you what the medical department of the Navy is trying to accomplish. We are facing some of the greatest problems we have ever been called on to face. We are working diligently and earnestly to solve these problems, but we realize that we need the help and the thorough understanding of our civilian contemporaries if we are to be successful in solving these problems.

In this atomic age, when the weapons and the nature of war are changing, the mission of our Navy has not changed. The oceans continue to be our cushions of defense, the bonds uniting us with our friends and allies, and our lifelines to overseas sources of raw materials which are so vital to not only our defense, but to our peacetime production. For many years to come we will have to depend on overseas bases, and this demands that we control the seas to operate and supply them.

Extent of Commitments

The United States had made a written bargain with 39 nations of the free world stretching across six continents which states that we shall consider any attack upon any of them as if it were an attack on ourselves. We have such an agreement with 13 nations in NATO, stretching across Europe, from Turkey to Norway. We have the Rio pact with 21 nations in the Americas and covering Canada and Greenland, which obligates us to defend them. We have agreements in the Pacific Ocean

*Presented at the 1955 KSMA Annual Meeting, Sept. 27-29, in Louisville.

with Australia, New Zealand, Japan, South Korea, the Philippines and other South Asia nations in the Middle East, to resist aggression in those areas. Thus the horizon of naval responsibilities is ever widening and the problems and responsibilities of the Navy Medical Department are likewise increased.

Purpose of Medical Service

The purpose of the Navy's medical service is to give necessary medical support to a highly technical and efficient fighting organization. This entails not only the care of the sick and injured, but also the maintenance of the health of the Navy. This is not comparable to civilian medicine which concerns itself mainly with individual patient care or hospitalization. To many civilian physicians the concept of military medicine is simply the medical care for active duty military patients. It is regrettable that this widespread belief exists. To think that our medical department can serve our naval forces by simply applying everyday medical principles to the man or woman in uniform, can result in neglect, loss of life, and even disaster to the nation. Naval medical personnel must enter into multiple strange enterprises; they must shoulder responsibilities which are unique and are assigned by the Congress, the joint chiefs of staff, the defense department or other higher authorities. Of course patient care is a military medical responsibility. The error in thinking, which I want to call to your attention, is to believe that it comprises the total naval medical effort and responsibility. The military patient responds to the same operative techniques or therapeutic procedures as do your patients. It is true that he may suffer more grievous wounds or be exposed to more bizarre diseases than the civilian citizen. Also, he may have to be operated on in the sick bay of a ship which is rolling and pitching on a storm-swept sea. It may be necessary to give him first aid in a dugout and to hospitalize him in a tent. Medical personnel have little difficulty in meeting such responsibilities. If this were all there were to it, then it would be a simple matter for the civilian physician, dentist and nurse to turn from their community practice to the role of a navy medical, dental or nurse corps officer and discharge their responsibilities with little or no indoctrination. This, however, is not the case, because naval medicine entails not only patient care and hospitalization, but such matters as submarine medicine, shipboard medicine, both shipboard aviation involving the task force carriers and land based aviation with the Marines. There are the problems of atomic medicine, cold weather survival and tropical medicine. Naval medical units also serve with Marine Corps ground troops and must be familiar with all phases of amphibious landings on hostile shores and with the underwater demolition teams in preparation for such landings.

The Responsibility of Prevention

One of the most important responsibilities of our medical department is seldom understood or recognized by the civilian. I refer to the responsibility of preventing disease and injuries. A quick glance at history reveals many examples which have been ignored by most civilian medical groups. In the first crusade an army of 300,000 was reduced to 20,000, and in the second crusade an army of half a million was reduced to a handful of returning stragglers. In the third crusade an army of 100,000 was reduced to 5,000. The great killer in these campaigns was not the sword, or arrow; it was scurvey, dysentery, plague and typhus. In 1812 Napoleon's army of 500,000 was reduced to 30,000, mainly by typhus. Many of you have read Hans Zinsser's "Rats, Lice and History." In it he states, "Soldiers have rarely won wars. They more often mop up after the barrage of epidemics, and typhus with its brothers and sisters—plague, cholera, typhoid, dysentery have decided more campaigns than Caesar, Hannibal, Napoleon and all the inspector generals in history." So today it is impossible for the military surgeon to relax behind the false security of quarantines, D.D.T. or all the antibiotic miracle drugs. To again quote from Zinsser:

"A concentration of large populations and cities, free communication with all other parts of the world, especially Africa and the East, constant and extensive military activities involved in the movement of large forces back and forth from all corners of the world—these alone are conditions which inevitably determine the outbreak of epidemic diseases."

The navy medical officer must take extraordinary steps in immunization, in enforcing sanitary measures, especially in invasion areas where no sanitation exists. He must control rats, lice, insects and other factors. If he lacks training and experience, and if he is not eternally vigilant, he may suddenly find the armed forces he is supposed to serve decimated

by an invisible but malignant enemy which penetrated the military defense in the form of contaminated food and water or in the bodies of lice or mosquitoes.

The Responsibility of Research

There is another great responsibility of the navy medical department and of all military medicine, and that is military medical research and certain purely military specialties. We have been criticized by various civilian medical groups for carrying out this responsibility. We do and will continue to work with civilian research groups whenever possible, but there are many problems with which trained and experienced military medical personnel has to work. Today we have jet planes that travel faster than sound and penetrate the stratosphere. We have the atomic powered submarine which must remain under the surface of the sea for long periods, or it must penetrate the depths of the sea. It is our job to determine whether the human body can stand these abnormal stresses and strains. Thus we are engaged in research in anoxia, vibration, noise, centrifugal force, wind blast, protection against atomic radiation. Our fighting men, your sons and daughters must be protected not only from disease and injury—they must be able to fight and survive in arctic cold or in jungle heat.

In Korea we wore armored vests made of plastic which was developed largely by medical personnel. I saw our Marines, wearing these vests, knocked down by missiles that before would have caused death by serious chest or belly wounds. Many suffered severe wounds of the extremities. We had some very fine young surgeons to take care of these casualties—they had only recently been called into active service from civilian hospitals. A good many of them were excellently trained by civilian standards, but lacked military experience in such things as triage and debridement. Valuable contributions were made to the armed forces in Korea by the fine clinical research done by Colonel John Howard and his army team in their studies of the physiology of combat wounds.

Mobility and Specialization

The navy medical department must be mobile. This is especially true in time of war when our practice is almost opposite that of the civilian concept of permanently located hospital and fixed equipment. We operate hospital ships which are brought in close to the fighting fronts and are ready to receive and care for casualties soon after zero hour. They are available and in use long before it is possible for our forces to be able to capture sufficient enemy held real estate, to set up tent hospitals, or provide landing strips for our planes. In World War II these magnificent ships were often thought of as ambulances and, while it is possible to provide complete hospital and specialists' care to our sick and wounded while enroute from the combat area to the continental United States, it is my opinion that their most valuable and vital role is that of a highly mobile base hospital in close support of fighting forces.

We have, in order to obtain maximum efficiency and utilization of highly trained specialists, organized surgical teams. These teams consist of a general surgeon, orthopedic surgeon, and physician anaesthetist plus the enlisted corpsmen technicians. These teams can be transported by plane or helicopter together with their instruments and supplies to any area where they are needed. The instruments and dressings are previously sterilized and packed in light-weight, water and dust proof aluminum chests. The team is therefore ready to operate on a moment's notice and they are used to augment the staff of hospital ships or Marine medical companies whenever the flow of casualties becomes unduly large.

Prior to the nineteenth century effective means of evacuating the wounded did not exist. Many battles were lost and the face of history changed because those who fell in battle were left unattended or uncared for until the battle was over. Napoleon was probably the first famous military leader to recognize this deplorable waste, and he demanded that his medical personnel treat the wounded during, instead of after, the battle. Even during our own Civil War countless lives were lost because evacuation of wounded was done by commandeering rickety carts and hucksters' wagons to transport the casualties. I need not recount more, because I am sure that all of you know the tremendous progress that has been made by the armed forces in improving the evacuation and care of the wounded. Today we have the helicopter, which can pick a man up almost as soon as he is wounded. During the Korean fighting these brave pilots went over hostile territory to pick up wounded from mountain crags or from icy seas. In a matter of minutes they were delivering their patients to our tent hos-

pitals or to the flight deck of our hospital ships. We have ambulance buses that travel on poor roads or on railroad tracks. We have the amphibious duwks that are able to travel on land or sea with equal agility. There are well equipped ambulance planes and railroad hospital trains.

Dependent Medical Care

There are many other roles and important responsibilities that our navy medical department must concern itself with, but time does not permit me to mention them all. In closing, however, I would like to briefly discuss our responsibility in the little understood field of dependent medical care. This problem is greatly concerned with the morale of our military personnel, but in my opinion it is of far greater importance in connection with the training of our medical personnel. Ever since the medical corps was first established there has been some degree of dependent care. The 48th Congress in 1884 provided in an appropriation act: "The medical officers of the army and contract surgeons shall, wherever practicable, attend the families of officers and soldiers free of charge." In 1947 when the Air Force became a separate service this authority was extended to that service. The navy followed the army practice until 1943, when, by Public Law 51, it was given congressional authority to care for dependents. If the splendid record of achievement of our medical department in World War II and the even better one in Korea prove anything, they prove that thousands of precious lives were saved because we had trained medical personnel. Of course civilian medical institutions helped tremendously in this training, but, in large measure, it was due to the great variety of clinical material available by reason of dependent care. It should be crystal clear to everyone that in order to make a military medical career attractive to competent people you must have professional work that is stimulating and satisfying. It must provide the same means for professional knowledge and advancemennt as found in the best civilian institutions.

Recapitulation

I have mentioned before what our world wide commitments are. This means that today we must maintain about one-third of our personnel at sea, or overseas all the time. It must be obvious that in many overseas areas and in remote areas of our own country there is no one to give medical care except the military. Is it reasonable to expect the military medical specialist to spend his entire career of 20 or 30 years aboard ship, in foreign lands or desolate and isolated areas? He must have the best kind of training to do his job. He must be as competent a specialist as his civilian counterpart, but he must live up to all the added responsibilities imposed by a naval career. He loves and serves his country and desires, just as you do, to live most of his days in America with his family and friends.

The United States has a great naval medical department—one of which we can all be justly proud. I ask that each of you give it your sympathetic understanding and whole-hearted support, and I can assure you it will become even greater in the future.

Manuscript Memos

Manuscripts should be submitted in duplicate to the Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Mr. J. G. Denhardt, Times-Journal Publishing Company, Bowling Green, Kentucky.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.


TRANS WORLD AIRLINES



ACHROMYCIN

Tetracycline *Lederle*

in the treatment of

respiratory infections

January and his associates[1] have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

No matter what your field or specialty, ACHROMYCIN can be of service to you. For your convenience and the patient's comfort, Lederle offers a *full* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.



For more rapid and complete absorption. Offered only by Lederle!

[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

Lederle

LEDERLE LABORATORIES DIVISION

AMERICAN CYANAMID COMPANY

PEARL RIVER, NEW YORK

*REG. U. S. PAT. OFF.

PHOTO DATA: 4X5 VIEW CAMERA, F5.6, 1/25 SEC., EXISTING LIGHTING AT DUSK, ROYAL PAN FILM.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1956 Annual Meeting Kentucky State Medical Association

Columbia Auditorium **Louisville, Kentucky** **September 18, 19, 20**

Fill Out and Mail to:

EVERETT L. PIRKEY, M. D., Chairman

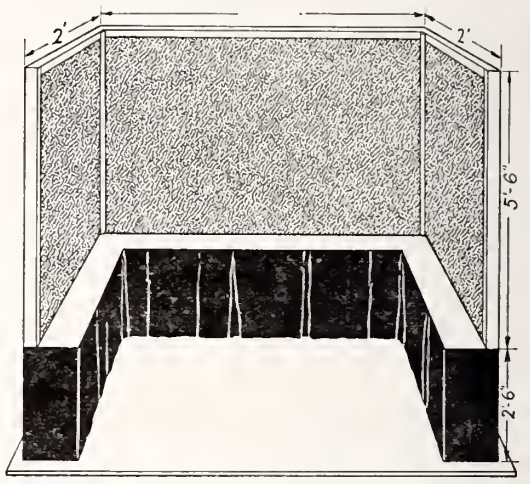
Committee on Scientific Exhibits

Louisville General Hospital,

Louisville 2, Kentucky

(Applications for space should be received before July 1, 1956)

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

Combined Laryngectomy and Neck Dissection In Continuity For Carcinoma of the Larynx*

ALVIN C. POWELEIT, M.D.
Covington
ROBERT C. KRATZ, M.D.
Newport

Lately the trend in laryngeal surgery has been toward the removal of the primary growth and the adjacent lymphatics to which the malignant cells are likely to metastasize. Perhaps the first man to recognize the advantage of enbloc removal of the primary lesion and associated lymphatics was Halstead when he introduced his radical mastectomy. Since this, the Miles procedure for carcinoma of the colon has also become accepted. Every forward looking surgeon realizes the necessity for adequate cancer surgery. There are, however, lesions that do not require radical surgery, the outstanding example of which is the basal cell carcinoma of the skin.

Classification

So it is with the larynx, some lesions require radical surgery and others do not. A step forward was made in the understanding of laryngeal cancer when Walsh classified the disease with respect to the therapeutic approach indicated.

(1) Intrinsic—Confined to the true cord only.

(2) Endolaryngeal — Involving structures within the laryngeal box, example the ventricles, ventricular bands, arytenoids and interarytenoid space, also those cancers of the vocal cord which have spread across the anterior commissure.

(3) Subglottic.

(4) Extrinsic or Extra-Laryngeal.

This is a primary lesion involving the epiglottis, aryepiglottic fold or the pyriform sinus lateral to the pharyngeal wall.

Criteria for Treatment

The following criteria for treatment of laryngeal lesions have been used in our private practice and in the cancer clinic at the William Booth Memorial Hospital.

The intrinsic lesions are relatively benign and eighty percent cures can be expected employing x-ray or surgery. Thornell[2] prefers to remove these with the suspension laryngoscope and electro cautery. Laryngofissure perhaps is the most frequently employed method.

The endolaryngeal structures are rich in lymphatics and lesions here bear a more serious prognosis. We believe that they should be treated with laryngectomy and radical neck dissection on the most involved side. We feel that from a cosmetic or functional standpoint the neck dissection adds little to the disability of the patient. These patients with the proper encouragement often develop an esophageal voice and are often able to carry on in their previous occupations.

Subglottic lesions we believe also deserve laryngectomy and enbloc removal of the neck on the most involved side. Ogura[7] found that in fifteen subglottic lesions, without palpable nodes in the neck, six were found to have microscopic metastasis present in the neck nodes.

Extralaryngeal lesions present the most difficult problems. As the surgeon's experience increases, more of these lesions become operable. We have recently successfully treated two lesions involving the lateral pharynx but we have passed the posterior pharyngeal lesions on to the radiologist.

We do not consider the procedure of removing the larynx and neck in one piece a prophylactic neck dissection. We reserve the term prophylactic for a procedure done separately from the original procedure. We consider this procedure as a removal of the primary cancer and its associated lymphatics.

In a series of 500 laryngeal cancers Bocca[4] has found the percentage of positive nodes to be as follows:

(1)	Supraglottic Marginal	73%
(2)	Vestibular	50%
(3)	Ventricular	30%
(4)	Cancer of the vocal cords	4%
(5)	Infraglottic cancer	46%
(6)	Cancer of the hypopharynx..	76%
	(Primary or secondary to laryngeal cancer)	

Presented at the 1955 KSMA Annual Meeting, Sept. 27-29, in Louisville.

(7) Diffuse cancerization of the larynx 90%

In more than half of the cases the metastases were clinically mute but they were demonstrated histologically.

Ogura[7] has shown that microscopic metastatic cells were present in the nodes of 38.8% of cases with laryngeal cancer despite the fact that no nodes were palpable on physical examination. In doing well over a hundred neck dissections of which forty percent had no palpable nodes in the neck Corgill[5] has found about the same percentage of node involvement as that described by Ogura.

Each of these men emphasizes that the percent of malignant cells found is directly proportional to the amount of time spent by the pathologist examining the specimen. They will spend three to four hours meticulously going through each specimen. They frequently find 75 to 80 nodes in a neck and then they make serial sections of each node found.

Since 1952 we have used the criteria presented in this article and the technique to be briefly described. To date, this procedure has been routinely applied in 10 patients all of whom are alive and free of metastatic disease. We realize that the time interval is too short to call any of our cases cures but we feel that the excellent exposure and simplicity of this technique deserves demonstration.

Technique

ANESTHESIA:

LOCAL—(NOVOCAINE 2%, ADRENALIN 1-1000, 3 minims, WYDASE 150 units to the ounce) Subcutaneous infiltration of skin along line of incision and to midline of neck.

GENERAL — Endotracheal — PENTOTHAL—Nitrous Oxide — Ether.

A U shaped incision as originally described by Laurens and popularized by Ogura is made. The area along the line of incision is infiltrated as above and infiltration anesthesia is carried subcutaneously toward the midline of the neck up to the level of the hyoid bone.

The skin flap is elevated to the body of the hyoid bone and also inferiorly and laterally. The anterior and external jugular veins are ligated and cut. The sternohyoid and sternothyroid muscles are divided and tied 1½-2 cms above the sternal attachment.

The thyroid isthmus is ligated and cut. Areolar tissue anterior to the space of Burns and lateral to the tracheal stump is dissected from the tracheal rings and left attached to the wall of the first tracheal ring.

After instilling 1cc of 10% cocaine into the tracheal lumen, the trachea is opened between the first and second tracheal rings. The tracheal stoma is then anchored with braided silk and endotracheal anesthesia is started. The extent of the laryngeal lesion is now determined.

Dissection is carried along the anterior border of the sternocleidomastoid muscle inferiorly, superiorly and posteriorly until the cricopharyngeal muscle is exposed. The superior thyroid vessels are ligated and cut close to the thyroid gland. The omohyoid muscle is cut and ligated. Separation of the larynx from the esophagus is now carried up to the arytenoids.

The cricopharyngeus muscle is ligated and cut posterior to the inferior and superior cornu of the thyroid cartilage. The superior cornu of the thyroid is isolated close to the base of the lamina and removed. The superior body of the hyoid bone is separated from the supra-hyoid muscles and isolated from the greater cornu of one side to the greater cornu of the other side. Dissection is carried to the vallecula. The superior laryngeal artery and vein are now ligated and cut before they pierce the thyrohyoid membrane.

The greater cornu, on the side opposite the tumor, is released from the periosteal bed. The larynx is retracted and rotated toward the side of the tumor.

The pyriform sinus is opened and enlarged by cutting across the base of the tongue close to the epiglottis and aryepiglottic fold as well as posteriorly and inferiorly to the arytenoid (2-3cms beyond limits of the tumor). The hypopharyngeal mucous membrane is now undermined.

The larynx is wrapped with gauze and radical neck dissection is begun. The sternocleidomastoid muscle is ligated and cut 2 cm from the sternal attachment. The omohyoid muscle is divided laterally and sutured. The internal jugular is isolated low in the neck and separated from the carotid artery and vagus nerve, doubly tied and transfixed and cut. Care should be taken on the left side in order not to injure the thoracic duct.

Dissection is carried upward over the lateral lobe of the thyroid. If there is any involvement of this lobe it should be removed en masse. The dissection is carried over the carotid up to the bifurcation.

The cricopharyngeal muscle is cut posteriorly to the inferior cornu and thyroid lamina. All areolar tissue overlying the prevertebral fascia is dissected from beneath the clavicle and lateral to posterior triangle and reflected superiorly. Dissection of areolar tissue is carried laterally until the anterior border of the trapezius muscle is reached and then superiorly along its anterior border. The spinal accessory nerve if possible should be saved; the greater auricular nerve is resected.

The submental space is now attacked. The areolar tissue is dissected down to the mylohyoid and reflected laterally along the ramus of the mandible. The anterior belly of the digastric muscle is cut and ligated. The submaxillary gland and lymph nodes are reflected laterally. The duct is ligated and cut. Care should be taken to preserve the lingual nerve.

Dissection is now carried superiorly from below. The hypoglossal nerve is found and dropped into its new position. Dissection is carried posteriorly at the angle of the jaw, removing the tail of the parotid gland. The facial artery is doubly ligated and cut. The internal jugular vein is separated and doubly ligated and transfixed beneath the jugular foramen. The sternocleidomastoid, stylohyoid and digastric muscles are sectioned close to the mastoid process.

The pharyngeal opening and esophagus are closed over a feeding tube with two rows of interrupted silk sutures. The cricopharyngeus muscles are brought together over the esophagus and sutured. In a like manner, the thyroid lobes are sutured together. The skin is closed with silk. Penrose drains are placed through stab wounds lateral to lower incision. A comfortably tight bandage is placed around the neck.

Comments

Clerf[9] does not subscribe to bilateral neck dissection except in epiglottic cancer. Orton[8] is in agreement with this. Bocca feels that bilateral neck dissection should always have an interval of three or four weeks between the two sides.

Conley[3] feels that operability does not have any relationship to curability and that many of the very extensive cases he has operated have been in the form of massive palliative efforts.

REFERENCES

1. Walsh, Theo. E.—The classification of Carcinoma of the Larynx. The Laryngoscope 57: 414-418 June 1947.

2. Thornell, Wm. C.—From the departments of Otolaryngology University of Cincinnati. Personal Communication.

3. Conley, John J.—From the Fack Medical Group, New York, N. Y. Personal communication.

4. Bocca, Ettore—Functional problems connected with bilateral radical neck dissection. The (British) Journal of Laryngology and Otology 67: 567-577 Sept. 1953.

5. Corgill, Donald—Veterans Administration Hospital, McKinney, Texas. Personal communication.

6. Laurens, Georges—Chirurgie De'Orielle, du Nez, du Pharynx et du Larynx. Textbook Paris Masson et Cie. 1936.

7. Ogura, Joseph H.—Laryngectomy and radical Neck Dissection for Carcinoma of the Larynx. The Laryngoscope Vol. 62 Jan. 1952.

8. Orton, Henry B.—Evaluation of radical neck dissection P 31—Transactions of the American Academy of Ophthalmology.

9. Clerf, Louis H.—Summary and Discussion—P 40—Transaction of the Academy of Ophthalmology and Otolaryngology.

The Use of Antibiotics In The Treatment of Pulmonary Tuberculosis*

E. R. GERNERT, M. D.

Louisville

Many drugs have been developed for the treatment of tuberculosis, but streptomycin, dihydrostreptomycin, para aminosalicylic acid and isonicotinic acid hydrazid are outstanding and only these will be considered.

Tuberculosis assumes many forms and pulmonary tuberculosis is the captain of them all, both in its incidence and in the number of lives it terminates.

*Presented at the 1955 KSMA Annual Meeting, Sept. 27-29 in Louisville.

Streptomycin

The microbes which produce streptomycin belong to the actinomycetes group of organisms, occurring abundantly in soils, manures, composts, fresh water basins and dusts. They are filamentous and branching organisms that bacteriologists consider as bacteria while mycologists are inclined to classify them with the fungi.

After extensive studies of many actinomycetes representing a great variety of species and strains, two cultures were found to yield the desirable antibiotic.

They both belonged to a species described as A. griseus, the first representative of which was isolated in this country in 1916 from the soil. The generic name of the organism was changed in 1943 from actinomyces to streptomycin.

Streptomycin is derived from three substances; streptidine, streptase and N. methyl—L. glucosamine.

Cultures of the tubercle bacilli have been reported to show an increase in granulation, a decrease in length and a loss of acid fastness after exposure to streptomycin.

There is evidence that resistance is usually, but not necessarily, a permanent thing, and is not altered by animal passage, repeated culture or storage. However, as high as 38.5% of cases retreated with streptomycin have improved. It appears to depend upon the degree of resistance of the bacilli in vitro. With highly resistant organisms, the lesions usually continue to progress. With organisms which exhibit intermediate degrees of resistance in vitro, the individual shows varying degrees of improvement. The majority of patients develop resistant organisms after four months of continuous therapy when streptomycin is given alone. However, drug resistance may occur at any time during the therapy. The sensitivity of the tubercle bacilli to streptomycin in vitro, accurately reflects the sensitivity of the organisms in vivo.

Patients who have yielded negative cultures during treatment and for sometime afterward, have shown drug resistant organisms at a later date when their culture became positive.

Patients with cavities and those with high bacillary count in their sputum, show an increased tendency to yield drug resistant cultures during streptomycin therapy.

Streptomycin while mainly bacteriastatic, may also be bactericidal.

The concentration of streptomycin is usually twice as much in the blood serum as in the whole blood.

Absorption from the alimentary canal is poor. In man when 600,000 units (one gram of streptomycin base=1,000,000, "S" units) were given orally, there was no evidence of absorption, as no streptomycin was found in the blood or the urine. In doses up to 4,000,000 units (four gm) only one percent was found in the urine and none in the blood.

There is very little absorption when streptomycin is administered by inhalation. However, there is a reduction in the amount of sputum and a decrease in the number of bacilli.

To ensure adequate serum and tissue fluid levels, intramuscular injections give best results. Peak levels occur 30 minutes to three hours after intramuscular injection, 45 minutes to three hours after subcutaneous injection and immediately after intravenous injection. Subcutaneous injections may give signs of acute streptomycin poisoning, as; restlessness, labored respiration, nausea, vomiting, ataxia, loss of consciousness and coma. Intravenous injections may cause death by respiratory paralysis or circulatory collapse.

Preparations of streptomycin in oil, beeswax and Solvecillin (a water in oil emulsion) have been used with disappointing results.

The preponderance of excretion of streptomycin is through the kidneys, being most rapid during the first four hours and reaching 30 to 60 per cent within 24 hours.

Toxicity

Tenderness and soreness at the site of injection may be lessened by adding one cc of one percent procaine hydrochloride to each four cc. of streptomycin solution. Flushing of the face, loss of appetite, dizziness, occasional fainting, tinnitus and severe kidney damage may occur, although the latter is rare. Cylinduria may appear in 48 hours and hyaline and granular casts after seven days. Albuminuria is observed in long term treatment, in 20 percent of cases. This is no indication to discontinue therapy. Paresthesia of the lips and fingers, blood dyscrasias, leukopenia, listlessness, semistupor, decreased respiration, mild conjunctivitis, photophobia, slow heart rate, giddiness, ataxia, headache, nausea, vomiting, decrease in muscle tone and positive Rhomberg may develop. Streptomycin has a selective action on the vestibular and auditory mechanism. These are the most characteristic and serious manifestations. The amount of the drug given and the length of time required to produce neurotoxicity varies considerably. Symptoms may occur as early as the seventh day and as late as six months.

Allergic reactions may cause an elevation of temperature the first or second day, followed by a maculopapular eruption, or exfoliation or even a fatal hemorrhagic dermatitis. Itching, pains in the joints and eosinophilia as high as 70 per-

cent also occur. The rash responds to antihistaminic therapy. After the rash subsides, a small dose of streptomycin (10 mg) may be given after three or four weeks to see if the patient is still allergic. If there is no reaction, one may proceed with caution. Allergic symptoms usually subside with the discontinuance of the drug. Treatment can sometimes be started again, without repetition of symptoms.

Clinical improvement occurs more constantly and more promptly than does roentgenographic improvement, usually becoming obvious within the first two weeks of therapy. It is manifested by a drop in fever, decrease in cough, decrease in sputum, weight gain and sense of well being.

Originally, three grams of streptomycin were given intramuscularly in divided doses during the 24 hour period. Due to vestibular disturbances, smaller doses were given with a decrease in toxic manifestations and no decrease in the therapeutic effects. One gram appeared as effective as three grams.

In the so called "good chronics" who are neither ill nor miserable it is well to withhold the drugs, unless they are given to convert a positive sputum.

The whole surgical approach has been revolutionized since the advent of streptomycin. Many patients have been saved the necessity of collapse therapy. Surgical procedures have been made much less hazardous and many patients previously considered inoperable have been saved by being made able to have surgery.

The present routine of one gram twice a week intramuscularly seems to give as good results as the daily injections, and can be given for two to three years with much fewer toxic reactions.

Results obtained with streptomycin and P.A.S. regimes, using streptomycin grams one twice a week and 12 grams P.A.S. daily, as measured by sputum conversion on culture, and roentgen stability have been good in up to 60 percent of far advanced cases, in 85 percent of moderately advanced, and almost 100 percent of minimal cases. Treatment should be continued for at least six months after stabilization is demonstrated by roentgenograms.

When given as inhalation, use 500 mgm. of streptomycin in 10 cc. of normal saline, administering one cc over a period of two hours.

In the pleural cavity, use 0.5 to one gram of streptomycin in 20 to 50 cc of normal saline.

In intravenous injections, if given, use 1.8 to 2.4 grams of streptomycin in two liters of normal saline, given at a rate of 20 to 25 drops per minute.

Streptomycin comes in vials containing one gram of the powder to which is to be added the dilutent, in two cc vials of solution for a single dose, and in 10 cc vials, in which one cc of the solution is equal to 0.5 grams.

Dihydrostreptomycin

Dihydrostreptomycin was obtained as the crystaline trihelianthate and crystaline reineckate. It is made by hydrogenation of streptomycin. It was first used in 1948.

It is qualitatively very similar to streptomycin with regard to chemotherapeutic and pharmacological effects. It is available as the sulfate and hydrochloride. It was found that catalytic hydrogenation using either platinum or nickel catalysis converted streptomycin into dihydrostreptomycin. No structural changes other than reduction of the carbonyl group into a carbinal group takes place.

It has the same antibacterial activity against the tubercle bacilli as does streptomycin. Organisms resistant to dihydrostreptomycin are resistant to streptomycin and vice versa.

The toxic properties of dihydrostreptomycin are about the same as those of streptomycin, especially nausea, vomiting, itching, rash, vertigo and deafness. The deafness comes on much later than with streptomycin, and may continue even after the drug is discontinued. It is more irritating at the site of injection.

Sensitivity to streptomycin does not always imply sensitivity to dihydrostreptomycin.

Preparations of dihydrostreptomycin and its administration are the same as those for streptomycin.

Para aminosalicylic acid

Para aminosalicylic acid is also known as P.A.S. It also comes as potassium P.A.S. Twelve grams P.A.S. contains 1800 mgm. of sodium ion. K.P.A.S. is preferred in patients with cardiac impairment, congestive heart failure and renal impairment. P.A.S. was first used in February, 1949.

Intolerance to P.A.S. is characteristically noted as gastrointestinal upsets, coming on about a week or more after starting the drug. Other symptoms are anorexia, nausea, vomiting and diarrhea. Some pa-

tients are continuously affected, others from time to time and some never. The older and sicker the patient, the more likely he is to have these symptoms. In hypersensitivity, there is fever, prostration, nausea, vomiting, skin eruption and leukopenia.

The cause of the upset has been variously attributed to the drug itself, an impurity contained in the preparation, or a substance that forms on standing. The common impurity that has been identified in the commercial preparations is meta-aminophenol. The aging of the drug seems to be a big factor in producing the symptoms.

P.A.S. comes in 0.5 gram tablets, coated and uncoated. The coated are supposed to prevent gastric upsets, but apparently are no better than the uncoated. It is also available in capsules and powder, the powder to be given in solution. The dose is 10 to 12 grams per day, usually given in four divided doses. It may be given intramuscularly as lyophilized P.A.S., if the patient cannot tolerate the drug by mouth.

In giving K.P.A.S., start with two gram doses four times a day. At the end of one week give five doses. After the second week give six doses and stay on this dose.

While P.A.S. has properties which inhibit the growth of the tubercle bacilli, its main function is to greatly prolong the length of time other drugs may be given without the organisms becoming resistant to them.

Amphojel when given with P.A.S. frequently prevents gastric upsets.

Isonicotinic acid hydrazide

Isonicotinic acid hydrazide is also known as Isoniazid and I.N.H. It was first synthesized in 1912, but it was not until 1951 that its antituberculous effects were demonstrated. Isoniazid and iproniazid are chemically related to nicotinic acid, and to the known anti-tuberculous agents amithiozone and pyrazinamide.

Maximum levels are generally obtained within two hours with detectable amounts still present after six to 24 hours. Penetrations in significant amounts into caseous pulmonary foci have been demonstrated.

I.N.H. is easily absorbed from the intestinal tract and readily distributed throughout the body tissue. While I.N.H. usually stimulates the appetite, reduces the temperature, slows the pulse, lessens the cough, decreases the sputum and gives the patient a sensation of well being with an increase in weight, there are many toxic symptoms. These are anorexia, nausea, dyspnea, constipation, muscle twitching, tremors, hyper reflexia, restlessness, insomnia, headache, occasionally convulsions, vertigo, urinary retention, peripheral neuritis, malaise, itching, dryness of mouth and sweating. When sweating occurs it involves chiefly the head, neck and upper chest. Neuritis when it occurs usually begins with a feeling of tingling in the fingers or toes and numbness may be present. Weakness and stiffness of the joints and tenderness of the calves may occur. Eosinophilia is frequently observed. There may be mental changes such as euphoria, depression, loss of memory, terrifying nightmares, inability to concentrate, personality changes, characterized by belligerence, aggressiveness, hyperactivity, visual and auditory hallucinations and paranoid psychosis. Abnormal bleeding as purpura, hemoptysis, hematuria and melena occur. The above usually appear within the first two weeks of treatment, reaching a maximum by the fourth to sixth week, and then gradually diminishing. Mental symptoms may not occur for three to six months. Restoration to the normal state is the rule within two to six weeks after stopping the drug.

I.N.H. may increase the frequency of attacks in epileptics. Pyridoxine up to 450 mgm. per day, may help prevent the seizures.

While some deaths have been attributed to the use of I.N.H. the majority of the symptoms are of minor clinical significance. However, termination of I.N.H. therapy because of toxic effects is necessary in about five percent of the cases. Reactions contraindicating further use of the drug are; pyschoses, convulsions, peripheral neuritis, allergic reactions and severe difficulty in micturation.

I.N.H. comes in 50 mgm. and 100 mgm. tablets. Four mgm. of I.N.H. per kilo of body weight provides a satisfactory dose. Roughly, one may give 200 mgm. per day to those patients of 100 pounds or less, and 300 mgm. per day to those over 100 pounds. There is a preparation of streptomycylidene isonictinyl hydrazine sulfate, (Streptohydrazid is Pfizer's trade name) which allows the administration of streptomycin grams one and I.N.H. 436 mgm., to be given as a single intramuscular injection.

While some individuals may take I.N.H. over a long period of time before resist-

ance of the bacilli occur, it is best to give it with P.A.S.

Conclusions

From the large number of toxic symptoms and the allergic effects of these drugs one may feel hesitant to use them, but these are greatly offset by the excellent results obtained by their use. For the most part these side effects subside in a few days to a few weeks after the discontinuance of the drugs. In some cases the drugs may be started again without a recurrence of the symptoms. Since these drugs have been purified the main symptoms now seen are gastric upsets, headaches, rash, itching and deafness.

While any of these drugs may be given for a few weeks before causing resistance in the tubercle bacilli, it is best to give P.A.S. in conjunction with whatever other drug is used.

All stages of tuberculosis have been helped by these drugs, some cases being arrested, while others were saved the necessity of other procedures. However, it must be recognized that they are adjuncts to other forms of treatment rather than, of themselves, a definitive therapy. The other forms are the defense powers of the host, bed rest, collapse therapy and excisional surgery.

These drugs may be given in various combinations, but the consensus of opinion is that streptomycin and P.A.S. is the best.

The Use of Varidase in Perforating Appendicitis*

RICHARD H. WEDDLE, M.D.

Somerset

The thought of enzymatic debridement of the abdominal cavity came to my mind after I had used it on a number of occasions for debridement of necrotizing wounds of the epithelial surfaces of the body, several cases of hemothorax and a few cases of empyema of the chest. I could not see any reason why enzymatic debridement of the abdominal cavity could not be carried out with the same substance in the face of any fibrinous or fibrinopurulent exudate into the abdominal cavity.

Streptokinase and Streptodornase

Historically speaking it has been known for many years that clotted human blood in vitro may dissolve spontaneously on standing, the theory being that the clot is digested by proteolytic enzymes in the blood. The principle of this activity is that the inactive proteolytic enzyme plasminogen, which exists in the euglobulin fraction of human plasma, may be converted to the active form of plasmin, by humoral activators or by the addition of various substances such as chloroform, epinephrine, ether, thymol, and trichloroacetic acid. It was observed that bacteria free filtrates of cultures of Streptococci caused a rapid lysis of plasma or fibrin clots. This kinase substance was given the name of Streptokinase because of its origin from the filtrates of Streptococci. It was believed that this kinase activated the reaction of plasminogen to plasmin in the euglobulin fraction of plasma and therefore initiated the digestion of blood clots. The complete mechanism of this reaction is as yet to be determined.

Further studies revealed another fraction in this Streptococcal filtrate which caused liquefaction of purulent exudates as well, so that it became apparent that there was another enzyme, a Streptococcal desoxyribonuclease which was responsible for these changes. This second enzyme was given the name of Streptodornase and was shown to cause the depolymerization of desoxyribonucleoprotein and desoxyribonucleic acid, the major constituents of viscous exudates. On further study it was felt that this Streptodornase enzyme consisted of a group of enzymes acting at various phases in the degradation of the complex protein molecule desoxyribonucleo-protein to its simpler purine and pyrimidine bases. The primary strains of hemolytic Streptococci producing these enzymes of Streptokinase and Streptodornase are liberated chiefly by the group A Streptococci. The product used, however, in this small series of cases was derived from Lancefield's group C since this group is non-pathogenic for man and appeared least likely to cause any serious side reactions. It has also been shown that the Streptokinase-Streptodor-

*Presented at the 1955 KSMA Annual Meeting Sept. 27-29 in Louisville.

nase enzymes have no effect whatsoever on living cells, that there is no alteration of viability and motility of the intact phagocytes and that phagocytosis can proceed normally. In summary of this enzymatic agent it may be stated that its action is:

1. Destruction of nuclear degenerating cells.
2. Disappearance of extra-cellular desoxyribonucleic acid.
3. Liquefaction of viscous purulent or fibrinous exudates.
4. Solution of clotted blood.
5. Greatly increased phagocytosis.

In contrast it has been shown that these enzymatic agents do not act upon fibrous tissue, muco-proteins or collagen. It has been stated that the local administration of VARIDASE causes a localized leukocytosis and attracts tissue fluid to the area within the first 24 hours. Because of the enhanced amoeboid leukocytosis, phagocytosis is encouraged, and as purulent or fibrinous debris is removed, antibiotics can attain contact with the infectious organisms in the lesion being treated. It has also been said that when these enzymatic agents are used in a closed space such as the pleural space, the influx of fluid and phagocytosis and the liquefaction of the exudate may produce an increase in fluid pressure with symptoms from increased tension. Under these conditions it is stated that provision must be made for aspiration and drainage, the frequency of aspirations depending upon the size of the closed space and on the patient's symptoms. A recent communication from the Assistant Director of Professional Services of the Lederle Laboratories Division stated that they could not at the present time recommend the instillation of topical Varidase into the abdominal cavity, the reason being that the absorption of breakdown products from clots and pus may produce reactions in the patient. It was also stated that the product should be used in areas where there is continuous drainage or where adequate drainage by needle could be established, as in the thoracic cavity. It was stated that complete withdrawal of fluid from the abdominal cavity would be an extremely difficult if not impossible procedure. I could not quite follow the line of reasoning in regard to increased tension due to abdominal fluid which could not be aspirated. I am sure many of us have had the experience of instilling these enzymatic agents into the pleural space and finding that after a short period of time there was no evidence of any residual hemothorax or pleural effusion. Supporting my line of reasoning is the fact that a certain amount of hyaluronidase was present in the product used. It is well known that hyaluronidase enable the body tissues to absorb fluids.

Reason for Trial

It was felt that the above reasoning justified a trial of enzymatic debridement in any present or impending purulent process such as a perforating or perforated appendicitis. This substance was not used in the acute or gangrenous appendix but only in those cases of appendicitis in which there was evidence of free abdominal seropurulent material in which it could be expected that abscess or fibrinous adhesive bands would form. It is my belief that the attitude toward operative procedure for appendicitis in this present day and age is not one of conservative therapy nor do I believe that once the diagnosis of appendicitis is made there is any contra-indication to surgery. The diagnosis of a ruptured appendix is difficult and the diagnosis of appendiceal abscess is as difficult or more difficult. The diagnosis of spreading or receding peritonitis likewise cannot be made with certainty. It is quite true that the mortality rates have declined markedly since the advent of the sulfa drugs and the antibiotics but according to Boyce the number of complications have increased and consequently the morbidity has lengthened. The increase in complications he ascribes to conservative therapy which means the use of the sulfas and antibiotics and the increase in use of purgatives at the onset of abdominal pain. In appendicitis the acute and gangrenous cases outnumber the complicated cases by about three to one with the complicated cases contributing three out of four deaths for an approximate 1.1% overall mortality; this in contrast to a 10.3% mortality in perforated appendicitis. Complications in 87 patients with perforated appendicitis listed by Massey and Vance consisted of 14 abscesses at one location or another, 67 early spreading peritonitis and six fulminating peritonitis.

Report of Series

I will now report 61 cases of acute perforative appendicitis in which the decision to use enzymatic debriding agents was made at the time of operation. These agents were used only in the abdominal

cavity and only when there was free seropurulent exudation. As previously stated the enzymatic agent was not used in cases of acute or gangrenous appendicitis nor in cases in which a definite abscess was demonstrated, fortunately or unfortunately, as the situation may be, our cases of appendicitis come from an area in Kentucky in which conservative treatment and the use of purgation at the onset of abdominal symptoms is still the treatment of choice with surgery being a last stand. The result of this is that many cases of appendicitis are seen in which perforation has already occurred. These reported 61 cases have been seen over a period of the last fourteen months. In a final analysis of these 61 cases, in which Varidase has been used intra-abdominally, there have been eight cases of ileus which required suction decompression, there has been one cul-de-sac abscess which was incised and drained and two cases of wound infection. In one case seen three weeks after surgery, with the primary complaint of tenesmus, it was felt after examination that the patient probably had a cul-de-sac abscess although the factors of surrounding induration and tenderness on rectal examination were absent, even though a mass was present. This patient, however, was admitted to the hospital and under anesthesia a needle was placed in the mass palpated on rectal examination. Through needle aspiration 360cc. of serous fluid was removed from the palpable mass. Culture of this fluid failed to reveal any organisms.

From a clinical point of view it is believed that these patients treated with the intra-abdominal use of Varidase show a somewhat longer febrile course than the non-Varidase patients. The postoperative febrile reaction in these patients tended to extend over a period of approximately five days before it returned to normal but the temperature recordings show no alarming elevations. It was not noted that there were any allergic manifestations as one might expect to be produced by the breakdown of protein material. With the exception of the one case mentioned it was not found necessary at any time to do abdominal or rectal aspirations.

Conclusion

It is my feeling at the present time that these enzymatic agents may be of some benefit in the prevention of the complications of the rupture of any of the hollow abdominal viscera and it might not be too far afield to imagine that these enzymatic agents might possibly have some effect in preventing postoperative abdominal adhesions.

BIBLIOGRAPHY

1. Miller, J. M.; Surmonte, J. A.; Ginsberg, Melton; Ablondi, F. A.: Clinical experience with the injection of Streptokinase intramuscularly in the treatment of infection and edema. Maryland State Medical Journal 4:4:; April 1955.

2. Teitelman, S. L.; Movitz, D., and Zimmerman, L. M.: Enzymatic Debridement of Necrotic Surfaces. Ann. Surg. 136-267-271 (Aug.) 1952.

3. Wright, L. T.; Smith, D. H.; Rothman, M.; Metzger, W. I., and Quash, E. T.: Use of Streptokinase-Dornase in Certain Surgical Conditions. J. Internat. Coll. Surgeons 15: 286-298 (March) 1951.

4. Miller, J. M.; White, B. H. and Long, P. H.: Streptokinase and Streptodornase in the Treatment of Surgical Infections. Lancet 1: 220-223 (Jan. 31) 1953.

5. Miller, J. M. and Long, P. H.: Surgical Principles Involved in the Clinical Use of Streptokinase and Streptodornase. Postgrad. Med. 11:188-195 (March) 1952.

6. Collins C. G. and Tucker, G. W.: The Use of Streptokinase and Streptodornase in Pelvic Abscesses. Preliminary Report. New Orleans M. & S. J. 104:385-389 (April) 1952.

7. Personal Communication. Lederle Laboratories Division: American Cyanamid Company.

8. Boyce, F. F. Acute Appendicitis: Conservative therapy versus first principles. Ann. Surg., 1951, 133: 428-432, March.

9. Boyce, F. F.: Fallacies in current therapeutic trends in acute appendicitis. New Orleans Med. & Surg. J., 1951, 103: 411-416, April.

10. Keyes, E. L. A new method for the early diagnosis of acute appendicitis in the absence of localization. S. Clin. N. Am., 1950, 30: 1447-1456, Oct.

11. Lulenski, C. R. Acute Appendicitis. Ohio M. J., 1950, 46: 121-124, Feb.

12. Massie, J. R., Jr., & Vance, J. The treatment of perforated appendicitis. Am. Surgeon, 1954, 20: 1194-1198, Nov.

13. Rhoads, J. E. & Darrow, R. P. Acute appendicitis and its complications. Penna. M. J., 1951, 54: 435-439, May

14. Shepherd, J. A. Acute appendicitis, a historical survey. Lancet, 1954, 2: 299-302, Aug. 14.

15. Weigel, C. J. Acute appendicitis with perforation. G. P., 1950, 1: 57-61, June.

CASE DISCUSSIONS

FROM THE UNIVERSITY OF LOUISVILLE HOSPITALS
LOUISVILLE CHILDREN'S HOSPITAL
A CASE OF LOBAR EMPHYSEMA*

Presentation of the Case

This six weeks old baby boy entered Children's Hospital November 28, 1955, with a history of rapid respirations and jaundice since birth. At birth he weighed eight pounds. He "was blue at birth and the physician had trouble getting him to cry." The mother noticed jaundice one or two days after birth which deepened and involved the sclerae. The respirations became more labored and grunting. The baby was breast fed but nursed poorly. At one week of age the parents took the child to their physician because the jaundice persisted, the respirations became worse, he was constantly fretful, and mild cyanosis occurred whenever he cried. His stools always remained yellow to yellow-green and his bowels moved one to three times daily. The urine was persistently yellow. At five and a half weeks of age the parents again returned to their physician, this time because the child had "colic" which term encompassed extreme fretfulness, grunting respirations, cyanosis when crying, inability to eat or sleep well, and failure to gain weight properly. The jaundice was diminishing.

In the admitting room the child became very cyanotic and required oxygen. He weighed nine pounds and one ounce, was very irritable and nursed poorly. Temperature was 99° (rectally), respirations 60-80, and pulse 144-150. The heart sounds were rapid and regular. No murmur was heard. Breath sounds were heard throughout both lung fields. There was hyper-resonance on the right. The remainder of the physical examination was nonessential. The laboratory reported: Hemoglobin 12.5, RBC 4.0, WBC 12,050, lym. 46, seg. 51, eos. 3; urine negative, urine urobilinogen negative; bilirubin direct .3, indirect 2.2. X-ray of the chest showed a remarkably emphysematous right upper lobe which had expanded well across the midline anteriorly and had compressed the right middle and lower lobes into a small segment of the right inferior hemithorax. The lung markings in the expanded lobe were well visualized and moderately separated. The heart and other mediastinal structures were slightly displaced to the left.

Management

The child's general condition became rapidly more critical as evidenced by his weak cry, grunting respirations, and inability to nurse properly. An emergency thoracotomy revealed that the right upper lobe was three times the size of the middle and lower lobes combined and was extremely emphysematous. The middle and lower lobes were completely atelectatic. The thymus, heart and mediastinum were shifted completely to the left side. By oc-



FIGURE 1

AP film showing marked emphysema of right upper lobe and displacement of mediastinal structures.

*Hospital Protocol No. 38906

cluding the right upper lobe bronchus, the middle and lower lobes could be completely expanded by the anesthetist. The right upper lobe was removed.

The baby did well. The sutures were removed on the fifth post-operative day and he was discharged on the seventh post-operative day. Six weeks after surgery he was gaining weight, eating and sleeping well, and respirations were normal. An x-ray at this time showed excellent re-expansion of the remaining lobes on the right. The heart and mediastinal structures were in the midline. The only evidence of operative intervention was the slight increased radiolucency of the right lung as compared with the left.

Discussion

I. Diamond, M.D.: Microscopically the lobe presented patchy areas of emphysema with interspersed areas of atelectasis. Most of the parenchyma was involved by a chronic interstitial pneumonia characterized by lymphocytic and reticulum cell infiltration of alveolar walls. Bubbles of air, typical of interstitial emphysema, were found in a few interlobular septa.

The bronchioles, almost without exception, were moderately dilated. The bronchi did not appear dilated and were free from inflammatory change. However, their cartilages were in some places abnormal. Several plates were distinctly immature. Two instances of cellular aggregates, not yet differentiated into cartilage, were seen in hilar bronchi.

Obstructive lobar emphysema, in our experience, is usually due to malformation and immaturity of bronchial cartilages. In view of the great variability in shape and amount of the bronchial cartilages in normal lungs, many cases cannot on morphological grounds, be attributed to malformation. Immaturity is easier to recognize and plates of pliable embryonic cartilage lend themselves easily to the hypothesis of expiratory bronchial collapse.

Hugh B. Lynn, M.D.: This is a typical case of lobar emphysema, one of the more unusual surgical emergencies of the newborn infant which has been well handled with an excellent final result.

Congenital lobar emphysema, while a relatively rare condition, will undoubtedly be more frequently detected as the medical profession becomes more alert to its existence. This case is typical of many others reported in which the difficulty arises early in life without any associated infection and which fails to respond to conservative treatment.

There are many explanations as to the etiology, all of which would indicate some form of ball-valve or check-valve mechanism. Whether this is on the basis of chondromalacia or other bronchial wall weakness which allows collapse on expiration, or whether it is due to some redundancy of the lining mucosa, is unknown. The first consideration in all of these cases is the possibility that a mucus plug is present, but bronchoscopy usually reveals little evidence of such a mucus collection, and any advantage gained from the bronchoscopy is rapidly lost. As has been pointed out by many authors, this is a condition of the upper lobes and while it does occur bilaterally on occasion, it is more frequently unilateral. This finding in itself would suggest the possibility of some localized abnormality such as a fold or positional kinking, rather than a generalized defect of the tracheal-bronchial tree. We prefer to consider this condition one of the prime surgical emergencies of infancy; we have been impressed with how little is accomplished by non-surgical supportive therapy. This youngster was in the operating room within three hours of the time his x-ray films were taken.



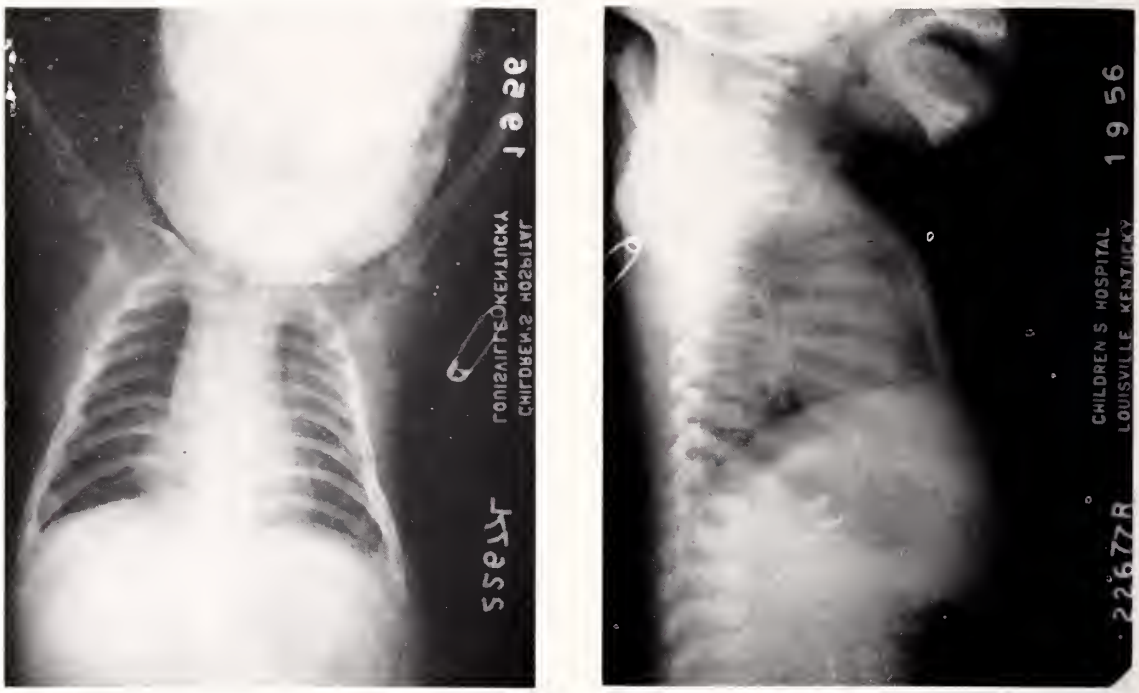
FIGURE 2

Lateral film demonstrating the emphysematous lobe in the retrosternal space and displacing the heart posteriorly.

While this is a relatively rare condition, a total of six cases has been observed in the Children's Hospital within the past 10 months. It is on the basis of this number that it was deemed worthy of reporting this patient.

Whenever this subject is discussed, the problem is raised as to whether repeated thoracenteses would not suffice instead of the more radical surgery. It is certainly true that pneumonic blebs or bullae might be deflated by needle thoracentesis, or at least that a series of such thoracenteses or closed tube suction might eventually produce a cure. However, we are strongly opposed to this treatment where an unequivocal diagnosis of lobar emphysema can be made because of the real danger of producing pneumothorax, empyema or broncho-pleural fistula.

This condition should be looked for in any newborn infant with respiratory symptoms. Unless treated promptly it may easily lead to death.



FIGURES 3 and 4

AP and lateral chest films six weeks post-operative

EDITORIALS

A PLEA FOR THE FUNDAMENTALS IN SURGERY

We who practice "the Queen of the Arts" are sometimes so carried away by the tremendous feats of surgery performed today in many parts of the country, of such magnitude as subtotal evisceration, cardiac operations, resection of all parts of the aorta and replacement with grafts, that we are prone to neglect consideration of the fundamental principles of our science and art which have gradually evolved over the years.

We who received our training in the years before massive transfusions, miracle drugs, artery banks, bone banks, superb anesthesia, et cetera, may wonder is present day surgeons are thoroughly cognizant of the teachings of the surgical giants who brought our specialty to its present stage of eminence.

Halsted is properly credited with having founded a school of surgery based upon the now universally accepted concepts of careful and complete hemostasis, absolute asepsis, gentle handling of tissues, the use of fine nonabsorbable suture material and accurate reapproximation of divided tissues. To these may be added incisions following the natural skin lines and creases, clean sharp dissection, careful replacement of blood and electrolytes, preoperative preparation of the intestinal tract and careful observation of renal function.

Since the advent of the miracle drugs it is very easy to become somewhat careless, if not sloppy. These drugs have and are saving thousands of lives but they are no substitute for rigid aseptic technique. I am somewhat in accord with W. A. Altmeier, M.D., who stated that he would dismiss a resident who gave penicillin prophylactically to a clean hernia case. The majority of the population will be sensitized to penicillin soon enough by its injudicious use. One hastens to add that bone surgery has been greatly expanded and made safer by the miracle drugs.

Incisions have one common requirement—adequate exposure.

Accurate hemostasis and gentle handling of tissues are self explanatory. One must avoid mass ligatures and attempt to clamp and ligate only the bleeding vessel.

Fine and perhaps nonabsorbable suture materials are generally accepted. We have used cotton with satisfaction since Ochsner's work was publicized, while many colleagues are equally successful with silk. Although the strength of the suture material need be no greater than that of the tissues approximated, I feel great comfort in using fine multifilament wire for vertical upper rectus incisions as well as those in which a bowel resection is done. I first saw this used by Arthur Allen, M. D., many years ago and its chief advantage is that it will not puncture a glove or finger. Wire has been widely used for years by many surgical teachers. Where catgut is used fine chromic is preferred after the excellent work of H. P. Jenkins, M.D., and co-workers.

Thanks to the intestinal antiseptics, open anastomosis of the intestine and colon has largely replaced closed methods but we owe a great debt to physicians Rankin, Allen, Welch, Parker, Kerr and others who perfected the closed methods. We have learned that the peritoneum is able to take care of far more infection than was previously suspected and that it is impossible to drain the peritoneal cavity. Hence there is much less intra-peritoneal drainage today. However, the fascia and fat are quite susceptible to infection and not infrequently require drainage. The delayed closure of contaminated wounds proposed by F. A. Coller, M.D., many years ago, is a most satisfactory procedure.

A drain in Morrison's pouch after a cholecystectomy is for us a routine necessity, although we went through a period of non-drainage. This practice is followed by physicians Allen, Coller, Warren Cole and many other excellent surgeons. We knew that occasionally the tie slipped off the cystic duct but now we know that almost 60% of cholecystic beds have anomalous ducts entering the gall bladder. Constant diligence must be exercised to identify all structures of the biliary duct region before any clamps or ligatures are applied. The rise in common duct strictures is distressing.

It goes without saying that all divided

layers should be carefully and accurately reapproximated and I would emphasize the posterior rectus sheath and the transversalis fascia.

My plea is that we keep in mind these fundamental principles of surgery and then indeed will the Latin axiom be true;

"Primum Non Nocere."

This may easily be translated, "safety first."

Branham B. Baughman, M.D.

WHAT KIND OF MEDICAL SCHOOL?

It is believed that the need for another medical school in Kentucky has been established. The reasoned, objective studies of Anderson and Manlove, the Legislative Research Commission and its Medical Advisory Committee together with "Medical Education in Kentucky," have all concurred in the urgent need. Realizing the need and mindful of the strong sentiment of the people of the state for a second school, the Board of Trustees of the University of Kentucky, at its June 1954 meeting, officially established a medical school at the University to be built when funds are available.

What kind of medical school is to be built? Great advances have been made in medical education and medical schools in the last half century and we are now in an era of experimentation and change.

The Flexnor report published in 1910 has been called the most important contribution to medicine in this half century. Teaching and research in the medical sciences were crystalized and perfected; science was emphasized in the art of medicine; the laboratory and the hospital were the chief instruments of the Flexnor ideal. These improved medical schools brought American medicine to world leadership. They were the most important factors in lengthening the span of life by nearly 25 years in the last half century.

After the Flexnor report emphasis was on perfecting undergraduate teaching and on research in the laboratory and the hospital. More recently the clinic or outpatient department is being emphasized. The clinic is becoming the center of teaching for senior students. The schools, organized or built earlier, are now building new clinics and the new schools are emphasizing in their planning, rather extensive clinic facilities.

Since World War II, two important advances have been made in medical schools. One has to do with the integration of the teaching and research of all the medical professions and fields, preferably under one roof. The University of Washington's Division of the Health Sciences consisting of schools of medicine, dentistry, nursing, pharmacy and public health is an example.

The other important recent advance is the medical center. The Texas medical center has been called the most important contribution to medicine in the last quarter century. It has to do with the integration of teaching, research and medical care. It is a loose federation of the medical school with the medical resources of the community. Each hospital or institution retains its autonomy and freedom, under its own board, but covenants to cooperate in teaching research and medical care. It effects teaching and research largely at the graduate level. It provides the ultimate—the last resort—in medical care.

More than 3,000 hospital beds have been built in Lexington in the last 25 years. It is believed that, with the stimulant of the medical school, the national trend to expansion of medical facilities, together with good promotion, 1200 additional hospital beds will be built in Lexington in the next decade.

In planning the medical school at the University of Kentucky all important advances should be considered. It should be remembered that the orthodoxes of tomorrow are among the heresies of today. The kind of medical school we build today will be reflected in the medical services of the state tomorrow. The medical school is the capstone of medicine; it is a determining factor in the quality and character of medical service. The school should be built in the context of the future. It would be unfortunate to build an obsolete medical school.

J. S. Chambers, M.D.

*The opinions expressed by the author, J. S. Chambers, M.D., on this subject do not necessarily reflect the views of the editor pro tem or of the KSMA.

ORGANIZATION SECTION

Refresher Courses to be Feature of KSMA Annual Meet

The 1956 Kentucky State Medical Association's annual meeting will be held September 18-20 at Columbia Auditorium in Louisville.

Two new groups will be included in the specialty group sessions which will be held this year on Wednesday afternoon, September 19. These two are the Radiology Group and the Orthopaedic Society.

Gant Gaither, M. D., Hopkinsville, chairman of the Committee on Scientific Assembly, said that two other new features are planned this year. Refresher courses for physicians will be held from 8 to 10 each morning Tuesday through Thursday.

Dr. Gaither said the color television which was so widely enjoyed at the 1955 meeting was not available for the 1956 session. In its place will be the refresher courses and color movies each morning.

"The addition of these two groups, the refresher courses and the movies, are a part of the many efforts being made to make the 1956 annual meeting the most successful one yet held in Kentucky and one of the best in the United States," Dr. Gaither said.

UMWA Representatives to Meet May 6 in West Virginia

The fourth conference on Medical Care in the Bituminous Coal Mine Area, will be held Sunday, May 6 in the Daniel Boone Hotel in Charleston, West Virginia. The conference is sponsored by the AMA Committee on Medical Care for Industrial Workers and the AMA Councils on Industrial Health and Medical Service.

According to Carl Fortune, M.D., Lexington, chairman of the KSMA Committee on UMWA Welfare and Retirement Fund, the Association will be represented by Gant Gaither, M.D., Hopkinsville, president; Richard Slucher, M.D., Louisville, president-elect; and J. Vernon Pace, M.D., Paducah, chairman of the Council, and his entire committee.

Dr. Fortune will present a report from Kentucky delegates. The report was drafted at a committee meeting at the County Society Officers Conference in Lexington, March 29. Four other states besides Kentucky will have reports presented at the meeting. They are: Pennsylvania, Tennessee, Virginia and West Virginia.

Other members of the KSMA's UMWA Committee are: George Archer, M.D., Prestonsburg; Clark Bailey, M.D., Harlan; George Brockman, M.D., Greenville; Thomas Gudex, M.D., Louisville; W. C. Hambley, M.D., Pikeville; C. D. Snyder, M.D., Hazard; Walter S. Coe, M.D., Louisville and Loman Trover, M.D., Madisonville.

A field trip through the coal mine areas of Bluefield and Beckley, West Virginia, is also planned for the conference.

Polio Vaccine Now Available At Local Drug Stores

Kentucky physicians can now buy their polio vaccine from local pharmacists. This announcement was made recently by R. E. Teague, M. D., State health commissioner. Since last fall all vaccine has been distributed through State and local health departments.

Physicians in many counties can still get free vaccine for indigent patients from local health departments, Dr. Teague said.

According to published reports 386,058 doses of vaccine have been allocated to Kentucky since general distribution began last fall.

Ky. Chapter of ACS to Meet May 18 at French Lick

The Kentucky Chapter of the American College of Surgeons will meet Friday, May 18, at the French Lick Hotel in French Lick, Indiana. The announcement was made by James Drye, M.D., Louisville, who is arranging the program.

According to Dr. Drye, the program for the meeting is as follows: The morning session will include talks by five physicians. The physicians and the topics of their speeches are:

Douglas Atherton, M.D., and Lytle Atherton, M.D., Louisville—"Uretero Sigmoid Anastomosis."

Charles C. Higgins, M.D., Cleveland—"The Role of the Specialist in the American College of Surgeons."

Kenneth Johnson, M.D., Chicago—"Fractures of the Larynx."

One more speaker, a gynecologist, will appear on the morning program. He has not yet been selected.

The afternoon session will include a symposium on "Surgical Gastroenterology." The speakers and their topics are:

Lester R. Dragstedt, M.D., Chicago—"Physiology of Peptic Ulceration."

Ralph Bowers, M.D., Memphis—"Biliary Surgery."

A third speaker, not yet announced, will speak on "Diseases of the Colon."

R. J. Noer, M.D., Louisville, will moderate a panel discussion on "The Gastrointestinal Tract." The three afternoon speakers will serve as panel members.

W. Vincent Pierce, M.D., Covington, is president of the Kentucky Chapter.

The Kentucky Surgical Society will meet the following day, May 19, in French Lick. The program for this meeting appeared in the March Journal.

Public Opinion Survey Shows People Like Physicians

Sympathy, patience, and understanding, **not** guaranteed cures and "wonder drugs," are the things people expect from their physicians.

This answer was a result of a recent AMA sponsored survey conducted by an independent research firm. The survey, made to find out what might be needed to improve physicians' services, was conducted among 4,000 citizens from various age, economic and geographical groups.

Major items shown by the survey were. 1. most people have their own family physician, and most people like him and most find the whole profession "likeable." 2. physicians are more critical of themselves than are other people. 3. most people do not think physicians are trying to get rich quick. 4. people are evenly split for and against "sliding scales" of fees.

The survey showed that patients are not critical of the physician's personality or ability. They are critical mostly of fees, coldness, impatience, lack of frankness and incompetence.

The survey revealed that of the 500 physicians included in the survey, most agreed that they do not give as much time as they would like and on lack of availability for emergencies. They felt most appreciated for their competence, sincerity, and healing abilities. About a fifth of the MDs thought there are not enough doctors in the United States.

Fifty per cent of the 3500 persons (excluding physicians) interviewed, had no knowledge of the American Medical Association.

Dr. Elkin, Lancaster, Appointed to UK Board of Trustees

Daniel C. Elkin, M.D., Lancaster, vice president of the Kentucky Medical Foundation, has been appointed a member of the University of Kentucky Board of Trustees.



Dr. Elkin

Dr. Elkin, former president of the Southern Surgical Association, is president-elect of the American College of Surgeons. During World War II, Dr. Elkin was chief of surgery at Ashford General Hospital at White Sulphur Springs, West Virginia. Dr. Elkin, once assistant in surgery at Harvard, holds medical degrees from Yale and Emory Medical Schools.

He retired two years ago as professor of surgery at Emory University School of Medicine and moved to his farm in Garrard County.

Pediatrics Post Graduate Course Scheduled May 1—June 19

The Kentucky State Medical Association is cooperating with the University of Louisville School of Medicine and the Kentucky Child Health Foundation in sponsoring a Pediatrics Post Graduate Course at Children's Hospital in Louisville, May 1 through June 19.

The course is under the direction of Alex Steigman, M.D., Louisville pediatrician. The program for the course is as follows:

Tuesday, May 1

Moderator: Alex Steigman, M.D.

9:30 a.m. Vomiting, Diarrhea—Clinical Cause
W. C. Adams, M.D.

10:30 a.m. Clinical Conference

11:30 a.m. Physiology of Fluids and Electrolytes—Office Application
W. A. Brodsky, M.D.

Tuesday, May 6

Moderator: Hugh B. Lynn, M. D.

9:30 a.m. Case Presentations

10:00 a.m. Ptosis and Congenital Anomalies of the Eyelids
Arthur Keeney, M.D.

10:30 a.m. Optimum Time for Elective Operative Procedures
Bernard Schoo, M.D.

11:00 a.m. Appendicitis, Hugh B. Lynn, M.D.

11.30 a.m. Hand Surgery
Harold Kleinert, M.D.

12:00 Subdural Hematomas
Everett Grantham, M.D.

Tuesday, May 15

Moderator: Joseph A. Little, M.D.

9:30 a.m. Fever—Office Differential Diagnosis Alex Steigman, M.D.

10:30 a.m. Clinical Conference

11:30 a.m. A Logical Approach to Tuberculosis in Infants and Children
W. C. Adams, M.D.

Tuesday, May 22

Moderator: W. C. Adams, M. D.

9:30 a.m. The Child's Normal Physical Growth Pattern
Frank Falkner, M.D.

10:30 a.m. Clinical Conference

11:30 a.m. Immunizations—Practical Program Fred Pipkin, M.D.

Tuesday, May 29

Moderator: Frank Falkner, M. D.

9:30 a.m. Evaluation of the Newborn Infant
Joseph A. Little, M.D.

10.30 a.m. Clinical Conference

11:30 a.m. Febrile Convulsions
Ephraim Roseman, M.D.

Tuesday, June 5

Moderator: W. A. Brodsky, M. D.

9:30 a.m. Care of the Well Baby: A Program of Preventive Pediatrics
Mary Cruise, M.D.

10:30 a.m. Clinical Conference

11:30 a.m. Differential Diagnosis of Palpable Liver, Spleen, Lymph Nodes
I. Diamond, M.D.

Tuesday, June 12

Moderator: Mary Cruise, M. D.

9:30 a.m. The Problem of Adolescence: Panel
Frank Falkner, M.D.
Pediatrics
Douglas Haynes, M.D.
Gynecologist

11:15 a.m. Meaning of Heart Murmurs in Children Joseph Little, M.D.

Tuesday, June 19

Moderator: Alex Steigman, M. D.

9.30 a.m. The Allergic Child
Alex Steigman, M.D.

10:30 a.m. Iron Deficiency Anemia in Infancy
T. D. Stevenson, M.D.

11:30 a.m. Question and Answer Period
Alex J. Steigman, M.D.
Post Graduate Instructors

Louisville Student AMA Chapter to Hear Walter Reed Doctor

Lt. Col. Eddy D. Palmer, chief of gastroenterology at Walter Reed Army Hospital, will be the guest speaker at the May 14 meeting of the Louisville Chapter of the Student AMA in the Rankin Amphitheatre at General Hospital in Louisville.

Bill Vonder Haar, president of the Louisville chapter, who made the announcement, said Col. Palmer will speak on "Gastrointestinal Bleeding."

A graduate of the Rochester Medical School, Col. Palmer did graduate work in parasitology at Tulane University School of Medicine.

The Louisville Student AMA Chapter will hold its election of officers May 26.

1956 National RH Meet is Best Wyatt Norvell, M. D., Says

The 1956 National Rural Health Conference in Portland, Oregon, March 8-10 was the best one yet, according to Wyatt Norvell, M.D., New Castle, chairman of the KSMA committee on Rural Health, who attended the meeting. Dr. Norvell said over 600 persons were registered during the conference.

"The enthusiasm and interest in bettering rural health conditions shown by all who attended the meeting was amazing and most gratifying," Dr. Norvell said.

An outstanding feature of the program was an address by Louis Rozzani, Clements, California, president of the California Farm Bureau Federation. Mr. Rozzani spoke on "What America Means to Me and My Doctor." George Lull, M.D., secretary-general manager of the AMA and Dwight Murray, M.D., AMA president-elect, were also featured speakers.

The discussions at the conference centered around the topic "Your Doctor and You." F. S. Crockett, M.D., Lafayette, Indiana, co-founder of the council, gave the keynote address on this subject.

The 1957 national conference will be held in Louisville March 7-9 at the Brown Hotel.

The Department of Medicine of the Johns Hopkins Hospital and the Johns Hopkins University School of Medicine will sponsor a six day postgraduate course for physicians primarily interested in internal medicine, May 7-12. Registration is limited to 150 physicians. Application blanks may be obtained by writing Philip A. Tumulty, M.D., Department of Medicine, The Johns Hopkins Hospital, Baltimore 5, Maryland.

Dr. E. Strode Urges Physicians to Name Award Candidates

Ernest Strode, M.D., Lexington, chairman of the KSMA Awards Committee, recently urged physicians to make their nominations of candidates to receive the Distinguished Service Medal and the Outstanding General Practitioner Award. These awards will be presented at the 1956 annual meeting.

"Let's give honor where honor is deserved," said Dr. Strode, "there are hundreds of physicians in Kentucky deserving recognition. It's a duty of physicians to nominate these men to receive some form of praise for their contribution to society."

The committee, which was activated at the 1955 annual meeting, will report its recommendations at the September 17 meeting of the KSMA House of Delegates. On September 19 additional candidates can be nominated from the floor.

Nominations can be made by contacting Dr. Strode or any of the other committee members—Hugh Adkins, M.D., Louisville; Joseph Kurre, M.D., Owensboro; Frank Sewell, M.D., Mt. Sterling; and Charles Yancey, M.D., Hopkinsville.

Three Post Graduate Seminars Held During March, April

The Kentucky State Medical Association in cooperation with the University of Louisville School of Medicine and the Kentucky Chapter of the American Academy of General Practice sponsored three post graduate seminars during March and April. The meetings were held at the Louisville General Hospital.

"These seminars were a part of KSMA's stepped up program of post graduate education," Garnett Sweeney, M.D., Liberty, chairman of KSMA's Committee on Medical Education, explained.

Participating in the March 27 meeting were the following physicians: J. Murray Kinsman, Grover B. Sanders, Robert L. McClendon, Ephraim Roseman and Richard C. Turrell.

These physicians presented papers at the April 5 seminar: Herbert Clay, Maurice Best, Leonard Leight, Walter S. Coe, Marion Beard, and Thomas Stevenson.

Six physicians participated in the April 12 meeting. Charles Duncan, James Hendon, Everett Sanneman, James Mosely, J. Richard Gott, Jr., and Arthur M. Schoen. All of the physicians are from Louisville.

Post Graduate Symposium Held in Beaumont Inn, Harrodsburg

One hundred and two persons attended the post graduate symposium Thursday, March 28, at the Beaumont Inn in Harrodsburg.

The symposium, a part of the Kentucky State Medical Association's program to present to members the latest and best developments and procedures in medicine, is sponsored by the KSMA, the University of Louisville School of Medicine, and the Kentucky Chapter of the American Academy of General Practice.

According to Garnett Sweeney, M.D., Liberty, chairman of the KSMA committee on Medical Education, the following physicians participated in the program: Walter S. Coe, Arthur M. Schoen, Arthur H. Keeney, and Douglas M. Haynes. All of the physicians are from Louisville.

Johnson County Society is Host at 14th District Meeting

The Johnson County Medical Society was the host at the annual meeting of the Fourteenth Councilor District April 19 at Paintsville.

Gant Gaither, M.D., Hopkinsville, president of the Kentucky State Medical Association, spoke at the dinner meeting. His address was entitled "Orvell 1984."

According to Paul B. Hall, M.D., Paintsville, who arranged the program, four physicians presented papers at the meeting. John Archer, M.D., Paintsville, is councilor from the 14th District.

Four Louisville Physicians Speak at 13th District Meeting

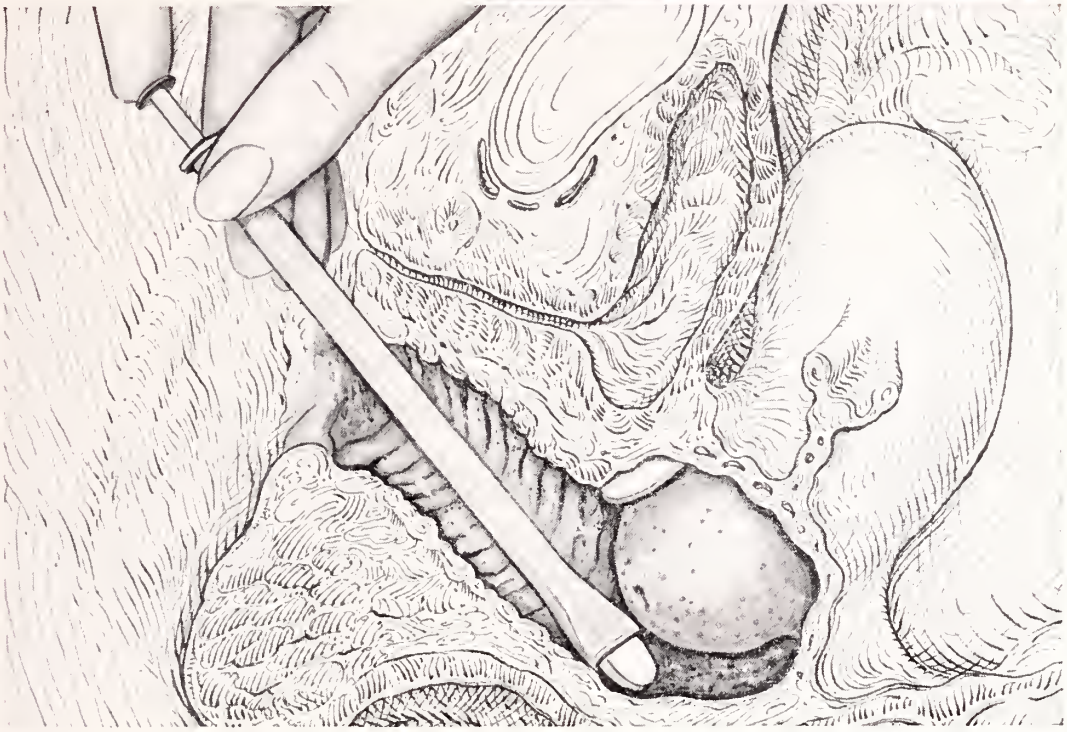
"Do You See What I See?" was the title of the dinner speech given by Gant Gaither, M.D., Hopkinsville, KSMA president, at the 13th Councilor District Annual Meeting, April 5, at Ashland in the State Tuberculosis Hospital.

The morning program, a symposium on diseases of the chest, featured three speakers. They were: Oren Beatty, M.D., Louisville; Albert Dickey, M.D., Madisonville and M. L. White, Jr., M.D., Huntington, West Virginia.

Participating in the afternoon program were the following Louisville physicians: Alvin Ortner, Laman Gray, and Walter Coe.

Charles Johnson, M.D., Russell, is the 13th District Councilor.

FLORAQUIN® VAGINITIS REGIMEN



New Intravaginal Applicator for Improved Treatment of Vaginitis

The restorative treatment of vaginitis with Floraquin is now further improved by a new aid to tablet insertion. Faulty insertion is no longer a failure factor in therapy.

The new Floraquin applicator is designed for simplified insertion of Floraquin tablets by the patient. This plunger device, made of smooth unbreakable plastic, places the Floraquin tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate. The patient inserts two Floraquin tablets with the applicator in the morning and also two tablets at night, with treatment being continued through at least two menstrual periods. During menstruation it is desirable to increase medication to eight tablets daily to combat the alkalinity of the menstrual flow.

Warm acid douches (2 ounces of 5 per cent acetic acid or white vinegar to 2 quarts of warm water) may be taken as often as desired for hygienic purposes.

Floraquin contains Diodoquin® (diiodohydroxyquinoline, U.S.P.), the safe and effective protozoacide and fungicide. Lactose, anhydrous dextrose and boric acid are included to help restore the normal acid pH of the vaginal secretions. Such an acid vaginal medium then encourages the growth of normal flora and makes the environment unfavorable for pathogens.

A Floraquin applicator is supplied with each box of 50 (a new package size) Floraquin tablets. G. D. Searle & Co., Research in the Service of Medicine.

New Floraquin Applicator and commercial package of 50 Floraquin tablets available on request to . . .

SEARLE

P. O. Box 5110, B
Chicago 80, Illinois

Dr. Gaither is Guest Speaker at Sixth District Meeting

Gant Gaither, M.D., Hopkinsville, president of the Kentucky State Medical Association, and Eugene M. Regen, M.D., Nashville, Tennessee, were the guest speakers at the March 13 dinner meeting of the KSMA's sixth councilor district at Bowling Green.

According to Harold Keen, M.D., Bowling Green, program arranger, Dr. Gaither discussed "Medical Legislation, Long Term View." Dr. Regen, scientific speaker for the evening, talked on low back pain.

Russell Starr, M.D., Glasgow, president of the district, presided at the meeting. L. O. Toomey, M.D., Bowling Green, is KSMA councilor from the sixth district.

Seven Heart Clinics Now Serving Nearly 40 Percent of State

Seven heart clinics, serving 44 counties, are now in operation in Kentucky, according to published reports. These clinics are for persons, children primarily, who cannot pay for medical care and whom physicians believe to have heart disease.

According to the report, the Kentucky Heart Association expressed the hope that the entire state will be served by these clinics within the next two years.

The seven clinics are located at Louisville, Bowling Green, Beattyville, Henderson, Hazard, Maysville and Paducah.

Mayfield MD Elected President of Kentucky OB-GYN Society

Robert A. Orr, M.D., Mayfield, was elected president of the Kentucky State Obstetrical and Gynecological society at the society's annual meeting in Lexington, March 3. Joseph Liebman, M.D., Frankfort, was named vice-president, and Edward Masters, M.D., Louisville, secretary-treasurer.

Henry R. Schraeder, M.D., General Hospital, Louisville, presented a paper at the meeting.

The society will hold its next meeting in October 1957.

U of K Dental School Proposed

Statements concerning the proposed establishment of a dental school at the University of Kentucky in connection with the proposed medical school were made by Lyman E. Wagers, D.M.D., Lexington, in an article in the KSDA's Journal, according to published reports. Dr.

CITY VIEW SANITARIUM

For the diagnosis and treatment of mental and nervous disorders, alcoholism and drug addictions

Established in 1907 by the late John W. Stevens, M. D.

52 acres near city. Separate buildings for men and women

Two full time psychiatrists

Electric shock and insulin therapy in selected cases

Occupational therapy

Physiotherapy department

Adequate laboratory facilities

NASHVILLE :—: TENNESSEE

All the benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress



Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra' are designed to help the physician cope with the problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids prednisone and prednisolone. Each Multiple Compressed Tablet is specifically formulated as a "tablet within a tablet" to provide stability and to release in sequence antacid and anti-inflammatory components.

NEW

'Co-Hydeltra'

Prednisolone Buffered

MULTIPLE COMPRESSED TABLETS

and

'Co-Deltra'

Prednisone Buffered

Supplied: Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra', each containing 5 mg. prednisone or prednisolone, 300 mg. of dried aluminum hydroxide gel, U.S.P., and 50 mg. of magnesium trisilicate, U.S.P., bottles of 30 tablets.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

'Co-Deltra' and 'Co-Hydeltra' are the trademarks of MERCK & CO., INC.

Wagers, a member of the Kentucky Medical Foundation, advocated more state aid for the University of Louisville Dental School.

AMA Annual Meeting is June 11-15

The 105th AMA Annual Meeting will be held in Chicago, June 11-15, at Navy Pier, Northwestern University and near by hotels. The House of Delegates' Headquarters will be the Palmer House.

About 350 technical exhibits and over 300 scientific exhibits will be on display to physicians and guests. Two of the scientific features already scheduled are: physical examinations for physicians and fracture and fresh pathology exhibits.

MD Returns to Health Department

William F. Lamb, M.D., who resigned in December as deputy State health commissioner, has returned to the State Health Department as director of local health services.

A graduate of Northwestern University Medical School, Dr. Lamb and Russell Teague, M.D., new Kentucky health commissioner, were classmates in graduate public health work at Johns Hopkins University.

Poll Shows MDs Oppose UK School

A post card questionnaire poll made by the Journal of the Kentucky Chapter of the American Academy of General Practice, showed that Kentucky physicians oppose a medical school at the University of Kentucky, but favor added State aid to the University of Louisville Medical School.

Carroll, L. Witten, M.D., Louisville, editor of the Journal, said 2,375 cards were mailed. Of those who replied more than 87 per cent opposed the building of a second school.

Dr. Massie Presents Exhibit

William K. Massie, M.D., Lexington, recently presented a scientific exhibit before the American Academy of Orthopaedic Surgeons' Convention in Chicago. The exhibit features a type of sliding nail that works like a telescope. It is used in repairing hip fractures. Carl Lange, Ph.D., professor of Physics at the University of Kentucky, helped design the nail.

"Neohydrin... offers the striking advantage of a high degree of therapeutic effectiveness upon oral administration."*

*Krantz, J. C., Jr., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, ed. 3, Baltimore, The Williams and Wilkins Company, 1954, p. 998.

98556

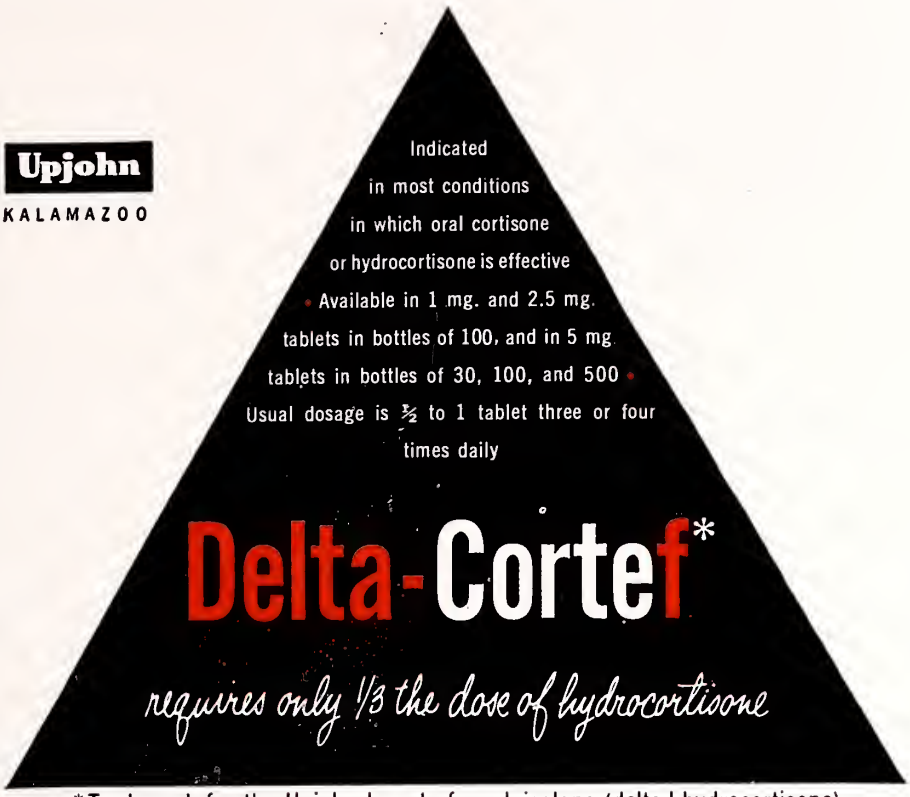
THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

unique
in successfully fighting malpractice charges

PROFESSIONAL PROTECTION EXCLUSIVELY SINCE 1899

LOUISVILLE Office
Calvin Bimer, Representative
3119 Hewitt Ave.
Tel. Glendale 8-3060
If no answer, call Clay 3636

Physicianss—Patronize your advertisers for they support the Journal.



Workshop on Handicapped Planned

A Conference and Workshop on the Handicapped will be held April 23-26 at the Brown Hotel in Louisville, according to Mrs. A. M. Frazier, executive secretary of the Kentucky Council for Handicapped, Inc. The conference is sponsored by the Nemours Foundation, the Kentucky Council for Handicapped, Inc., the University of Kentucky and the Office of Vocational Rehabilitation, Department of Health, Education and Welfare.

The Kentucky Council for Handicapped, Inc., was incorporated a few months ago, according to Mrs. Frazier, and membership is open to all state and local agencies and any interested individual.

AMA Releases Insurance Report

The AMA's Council on Medical Service recently released a 32 page report giving summaries of opinions of approximately 8,000 physicians on aspects of voluntary health insurance. The report is entitled "Summary of Survey of Physicians' Attitudes Toward Voluntary Health Insurance."

Some results of the report are: 1. The majority of respondents felt that health insurance should be underwritten by all agencies on a competitive basis. 2. Over half expressed the opinion that the function of such programs was to provide financial assistance. 3. Over three-fourths of the respondents felt that insured patients should pay some portion of medical care costs in addition to the insurance. 4. Most believed insurance should attempt to cover only a "substantial portion" rather than the entire fee.

ICS to Meet in Chattanooga

The Southeastern Division Regional Meeting of the International College of Surgeons will be held April 30 and May 1 in the Read House at Chattanooga, Tennessee. William G. Stephenson, M.D., Chattanooga, made the announcement.

West Virginia MDs to Meet

The fourth annual scientific assembly of the West Virginia chapter of the American Academy of General Practice will be held April 14-15 in the Daniel Boone Hotel at Charleston, West Virginia. Announcement of the meeting was made by Halvard Wanger, M.D., assembly chairman.

Dr. Higdon Testifies on HR 7225

Leon Higdon, M.D., Paducah, member of the KSMA Legislative Committee, testified on HR 7225 before the Senate Finance Committee in Washington, D. C., February 22. Dr. Higdon testified on the part of the bill concerning participants in social security who are 50 or over being eligible for full benefits when they are declared permanently or totally disabled.

Each state having a senator on the Senate Finance Committee was asked to send one representative to discuss the bill. Kentucky's senator-member is Alben Barkley. Dr. Higdon's testimony was authorized by the KSMA Executive Committee.

WA Sponsors Safety Program

The second annual medical forum sponsored by the Woman's Auxiliary to the Jefferson County Medical Society, was held March 20 in the Columbia Auditorium in Louisville. The forum was entitled "Antidotes for Auto Accidents."

R. Arnold Griswold, M.D., Louisville, chairman of the committee on trauma of the American College of Surgeons, was the guest speaker. Two other Louisville physicians took part in the program. They were: Arthur Kasey, Jr., and William Keller.

AMA Releases Film on Cancer

"Medicine USA—the Living Proof," a half hour television report on cancer survival based on case histories of eight people, has been released on film for presentation over local television stations under the sponsorship of local and state medical societies.

Kentucky physicians interested in showing the film, an AMA public service project, should contact the KSMA Headquarters Office, 620 South Third, Louisville.

KPA Wants Old Apothecary Shop

A Kentucky Pharmaceutical Association committee recently discussed restoration plans for the old apothecary shop next to McDowell House. The shrine, in honor of Ephraim McDowell, M.D., pioneer surgeon, is supported by the KSMA and the Kentucky Surgical Association.

According to published reports the KPA must raise $9,000 by April 5 if the option is to be taken up. They have already paid $1,000.

Medical School Gets $29,195 Grant

The University of Louisville School of Medicine has received a $29,195 grant from the National Fund for Medical Education.

This is the fifth grant made to the medical school by the fund which is contributed to by corporations and physicians. The fund has paid a total of $119,976 to the school.

Med Techs to Meet April 28-29

The Kentucky State Society of Medical Technologists will meet April 28-29 in Louisville at the Brown Hotel.

Ruth Robinette, M.T., of the KSSMT, who made the announcement, said the scientific program will be held on April 28 from 10 A. M. to 12:30 P.M. She said all physicians were invited to attend.

New KSMA Members

The following physicians were recently added to the KSMA membership roster.

Robert W. Fidler, M.D., Flemingsburg
Jerry B. McKenney, M.D., Marion
O. M. Richardson, M.D., Elizabethtown
Charles B. Spalding, M.D., Bardstown
William P. Wharton, M.D., Lexington

Kentucky physicians unable to attend the AMA Annual Meeting in Chicago during the week of June 11, can see the highlights of the affair on the final "March of Medicine" show in the 1956 spring series. The program, presented by Smith, Kline and French Laboratories, is carried over NBC-TV.

The Schering Corporation of Bloomfield, N. J., has announced its 11th annual award program for medical students in the United States and Canada. Students are asked to submit papers on one of three suggested subjects: 1. The Clinical Use of Adrenocortical Steroids in Collagen Diseases. 2. Metabolic Aspects of the Aging Process. 3. New Applications of Antihistamines in Medicine and Surgery. A first prize of $500 will be awarded and a $250 second prize will be offered for each of the three subjects. Entry forms, which are available in medical schools, should be submitted before July 1—manuscripts not later than Sept. 30.

Throughout the world...

use in millions of cases and reports by thousands of physicians have built confidence in

TERRAMYCIN®

BRAND OF OXYTETRACYCLINE

... well-tolerated, rapidly effective broad-spectrum antibiotic of choice.

Capsules, tablets, taste-tempting liquid forms and special preparations for parenteral, topical and ophthalmic use.

Pfizer

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N.Y.

News Items

J. E. Stephenson, M.D., has begun a practice limited to general surgery in Ashland. A 1942 graduate of the University of Louisville, Dr. Stephenson interned at Charity Hospital, New Orleans, Louisiana.

John C. Bates, M.D., has become associated with the Elizabethtown Clinic. Dr. Bates was graduated from the University of Louisville School of Medicine in 1952. He served an internship at the Louisville General Hospital. Before going to Elizabethtown Dr. Bates practiced medicine at Horse Cave and Leitchfield.

John G. Casey, M.D., has begun a practice at Pleasure Ridge Park. Dr. Casey, formerly of Brandenburg, was graduated from the University of Louisville School of Medicine in 1950. He interned at the Gorgas Hospital in the Canal Zone.

William C. Roland, M.D., recently announced the opening of an office in Ashland for practice limited to orthopedic surgery. A 1942 graduate of the University of Southern California Medical School, Dr. Roland interned at the US Naval Hospital, San Diego, California. He was a fellow in orthopedic surgery at Lahey Clinic, Boston, Massachusetts. Dr. Roland has served two residencies in orthopedic surgery—Shriner's Hospital for Crippled Children at Greenville, South Carolina, and US Naval Hospital at Chelsea, Massachusetts.

Samuel R. Scheen, M.D., a 1953 graduate of the University of Louisville School of Medicine, has opened an office in Covington. Dr. Scheen interned at the St. Joseph Infirmary in Louisville. He served a residency at the Department of Dermatology of the General Hospital in Cincinnati, Ohio.

A. O. Cull, M.D., has opened an office in Owenton. Dr. Cull, a 1950 graduate of the University of Louisville School of Medicine, served an internship at St. Lawrence Hospital in Lansing, Michigan. He began his medical practice in 1951 in Corinth.

Alex J. Steigman, M.D., chairman of the Department of Pediatrics at the University of Louisville, has been appointed special consultant to the Communicable Disease Center of the Public Health Service, Department of Health, Education and Welfare. Dr. Steigman was graduated from the Temple University School of Medicine in 1938. He has been in Louisville at the General Hospital since 1950.

A new Medical Research Center costing approximately $10,000,000 is being planned by Parke, Davis and Company, according to Harry J. Loynd, president. Construction of the proposed structure is expected to take two years. The exact location for the Center has not been decided.

The AMA Committee on Medical Care for Industrial Workers has prepared two publications dealing with the problem of work absence. The first is a reprint from the January 1956 issue of **Archives of Industrial Health** titled "A Syllabus on Work Absence". The other pamphlet is titled "Company Medical Program and Work Absence—10 Case Studies". Copies of these publications are available free of charge from the AMA.

Leonard A. Scheele, M.D., has been named surgeon general of the Public Health Service for a third-four year term. Dr. Scheele, 48, has been with the health service since 1933.

THE NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL (Organized 1881)
(The Pioneer Postgraduate Medical Institution in America)

PROCTOLOGY and GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; witnessing operations; ward rounds; demonstration of cases; pathology; radiology; anatomy; operative proctology on the cadaver; attendance at departmental and general conferences.

PRACTICAL ELECTROCARDIOGRAPHY

A two weeks part time elementary course for the practitioner based upon an understanding of electrophysiologic principles. Standard, unipolar and precordial electrocardiography of the normal heart. Bundle branch block, ventricular hypertrophy, and myocardial infarction considered from clinical as well as electrocardiographic viewpoints. Diagnosis of arrhythmias of clinical significance will be emphasized. Attendance at, and participation in, sessions of actual reading of routine hospital electrocardiograms.

For Information about these and other courses Address
THE DEAN, 345 WEST 50th St., New York 19, N. Y.



tolerance . . . . . *the key*

to successful

IRON THERAPY

Fergon®

IRON WITHOUT IRRITATION

NO NAUSEA
NO ABDOMINAL CRAMPS
NO CONSTIPATION
NO DIARRHEA

higher hemoglobin response

Supplied:

Fergon, tablets of 5 grains, bottles of 100 and 500.

Fergon, tablets of 2½ grains, bottles of 100.

Fergon elixir 6% (5 grains per teaspoonful), bottles of 16 fl. oz.

New

HIGH POTENCY **Fergon Plus Improved Caplets®** (Fergon with vitamin B_{12} and intrinsic factor, folic acid and vitamin C; 2 Caplets = 1 U.S.P. oral unit of antianemia activity), bottles of 100 and 500 easy to swallow Caplets.

Winthrop LABORATORIES NEW YORK 18, N. Y.

Fergon (brand of ferraus glucanate) and Caplets, trademarks reg. U.S. Pat. Off.

County Society Reports

CALLOWAY

The regular monthly meeting of the Calloway County Medical Society was held January 3 at Murray. John Quertermous, M.D., vice-president, presided.

J. A. Outland, M.D., advised the physicians to turn over to him all of the polio vaccine they had left and not give any more until a new supply comes in. He explained that the latest reports warned against giving any vaccine that had lost its color.

Dr. Outland said that the State Board of Health had offered suggestions for methods of keeping more complete files on infants who have been given shots.

Physicians present at the meeting were: A. D. Butterworth, Robert Hahs, Hugh Houston, C. H. Jones, O. K. Mason, J. A. Outland, John Quertermous, Charles Tuttle, Harry Whayne, and Vernon Pettit.

Hugh L. Houston, M.D., Secretary.

JOHNSON

The Johnson County Medical and Dental Society met January 31 at the Paintsville Country Club.

P. B. Hall, M.D., reported to the group on plans for the councilor district meeting, April 12 in Paintsville.

The following officers were elected for 1956: Robert A. Hall, M.D., president; Morris M. Hall, M.D., vice-president; and Augustus D. Slone, M.D., secretary-treasurer.

A discussion was held concerning a medical school at the University of Kentucky. The following resolution was adopted by the society.

"Resolved that the Johnson County Medical Society and the Johnson County Dental Society go on record favoring and urging the establishment of a medical and dental school at the University of Kentucky."

The secretary was instructed to send a copy of the resolution to Governor Chandler, and to Mr. Stephen White and Mr. Russel White, president and secretary of the Kentucky Medical School Foundation at Lexington.

Augustus D. Slone, M.D., Secretary.

LETCHER

The Letcher County Medical and Dental Society held its bi-monthly meeting February 28 at the Letcher County Health Offices.

E. Stanton Maxey, M.D., and Ralph Gambrell, M.D., new society members, gave case reports of their past practices.

A discussion was held concerning the "staffing and how patients would be admitted to the new Whitesburg Memorial Hospital."

The following members were present at the meeting. Owen Pigman, M.D., Carl Pigman, M.D., Lee Moore, D.M.D., E. G. Skaggs, M.D., T. M. Perry, M.D., E. Stanton Maxey, M.D., Ralph Gambrell, M.D., Fred Coffey, D.M.D., and R. Dow Collins, M.D.

R. Dow Collins, M.D., Secretary.

PIKE

The Pike County Medical Society held its regular monthly meeting February 21 in Langley's Cafe at Pikeville. Nineteen members were present.

The problem of allowing the County Health Department and the National Foundation of Poliomyelitis give the third and final shot to the children who had taken the first two shots under the Foundation Plan was raised. It was decided that these children should all receive their third shot through the Health Department.

Adam Osborne, M.D., was elected delegate to KSMA and T. I. Doty, M.D., was named alternate delegate. Both will serve for one year.

It was unanimously voted that Fred Quincy, M.D., be notified that he is an emeritus member of the society.

The motion that the annual dinner meeting be held in September rather than May was made and carried.

Motion to amend the Constitution was made by Ballard Cassady, M.D. The motion follows:

That Chapter 1, Section 1, Part a, subdivisions be increased to 5, and that subdivision 5 read as follows:

"In addition all members of the Society will be expected to carry his share of the charity load of the county and care for the sick without regard to fee as indicated."

Final vote on this amendment will take place at the next meeting.

Ballard Cassady, M.D., Secretary.

SHELBY-OLDHAM

The Shelby-Oldham County Society held its February meeting in Simpsonville at the Old Stone Inn. Twenty one members were present.

Nathan Levene, M. D., Louisville, was the scientific speaker for the meeting. He spoke on "TB Today."

C. C. Risk, D.D.S., Secretary.



Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

C I B A
Summit, N. J.

2/2225M

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

- Tax Returns
- Bookkeeping
- Delinquent Accounts (No Commission)
- Office Routines
- Office Planning
- Instructing Personnel
- Fees
- Partnerships
- Hospitals
- Clinics
- Counselling - Investments Insurance

ASSOCIATES:

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hubert G. Stiffler
Daniel L. Zeiser
Richard J. Conklin

Available

PROFESSIONAL BUSINESS MANAGEMENT

FOR DOCTORS ONLY

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945
WOodburn 1-1010
141 West McMillan Street
Cincinnati 19, Ohio

I would like to talk with one of your representatives

Name.....

Address.....

..... Telephone.....

All Services Completely Confidential

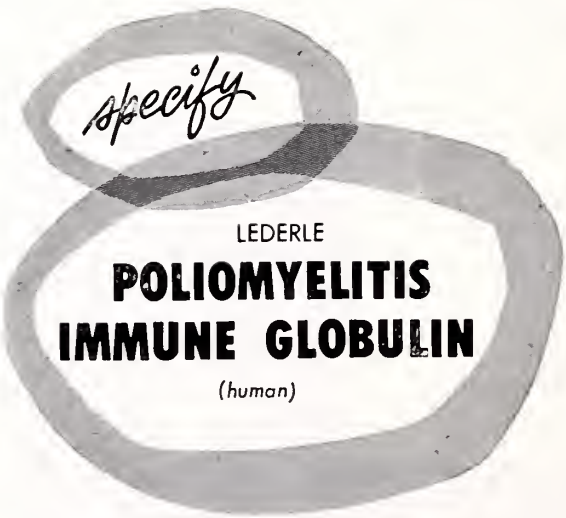
the most complete optical service in kentucky

Southern Optical COMPANY

Since 1897

4th and Chestnut
334 W. Broadway
LOUISVILLE

GUILD OPTICIANS



Lederle

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY Pearl River, New York

NEW CASTLE SANITARIUM

Telephone 3621
NEW CASTLE, KY.

For the care of
CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the American Hospitol Association
Member of the Americon Assn. of Nursing Homes
Licensed ond Approved by the State of Kentucky

SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE

PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS

24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES
New Selectemp Modulated Steom Heot With Filtered Air For Maximum Comfort and Sofety
Protected Throughout With Automatic Fire Detection and Alarm System

IRA O. WALLACE, Administrotor

PATRONIZE THE ADVERTISERS IN THE JOURNAL

All the benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress



Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra' are designed to help the physician cope with the problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids prednisone and prednisolone. Each Multiple Compressed Tablet is specifically formulated as a "tablet within a tablet" to provide stability and to release in sequence antacid and anti-inflammatory components.

NEW 'Co-Deltra'
Prednisone Buffered

MULTIPLE COMPRESSED TABLETS

and

'Co-Hydeltra'
Prednisolone Buffered

Supplied: Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra', each containing 5 mg. prednisone or prednisolone, 300 mg. of dried aluminum hydroxide gel, U.S.P., and 50 mg. of magnesium trisilicate, U.S.P., bottles of 30 tablets.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

'Co-Deltra' and 'Co-Hydeltra' are the trademarks of MERCK & CO., INC.

WAYSIDE HOSPITAL

168 North Broadway
Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

APPROVED BY AMERICAN MEDICAL ASSOCIATION

STAFF

H. HALBERT LEET, M. D. — JOHN H. ROMPF, M. D.
CARL WIESEL, M. D. — IRVING A. GAIL, M. D.

EDWARD L. HOUCHIN, ADMINISTRATOR

Phone: 2-2050

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465 **WAbash 6725**
334 W. BROADWAY
LOUISVILLE, KENTUCKY

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**
( ) **Centralized Bookkeeping** (Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**

OCULISTS' PRESCRIPTIONS EXCLUSIVELY

MUTH OPTICAL COMPANY

Prescription Opticians

We maintain our own manufacturing and grinding laboratory

665 S. 4th **Brown Hotel Building** **Louisville 2**



Clearview

On The Kratzville Road
EVANSVILLE, IND.

TELEPHONE 5-6181

A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.

SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery

ELECTROENCEPHALOGRAPH—CLINICAL LABORATORY — EKG AND BMR EQUIPMENT — STEREOSCOPIC X-RAY—HYDROTHERAPY

Albert J. Crevello, M. D.

Diplomate, American Board of Psychiatry & Neurology, Inc
MEDICAL DIRECTOR



in arthritis
and
allied disorders...

nonhormonal anti-arthritic

BUTAZOLIDIN®

(brand of phenylbutazone)

relieves pain • improves function • resolves inflammation

Employing the serum protein-polysaccharide ratio (PR) as an objective criterion of rheumatoid activity, it has again been shown that BUTAZOLIDIN "...produces more than a simple analgesic effect in rheumatoid arthritis."[1]

Clinically, the potency of BUTAZOLIDIN is reflected in the finding that 57.6 per cent of patients with rheumatoid arthritis respond to the extent of "remission" or "major improvement."[2]

Long-term study has now shown that the failure rate with BUTAZOLIDIN in rheumatoid arthritis, and particularly in rheumatoid spondylitis, is significantly lower than with hormonal therapy.[3]

(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. 1:168, 1955. (3) Halbrook, W. P.: M. Clin. North America 39:405, 1955.

BUTAZOLIDIN® (brand of phenylbutazone). Red coated tablets of 100 mg.

BUTAZOLIDIN *being a patent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before instituting therapy.*

GEIGY PHARMACEUTICALS Division of Geigy Chemical Corporation
220 Church Street, New York 13, N. Y.
In Canada: Geigy Pharmaceuticals, Montreal

5115S

Geigy

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your eligible dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

SECLUSION MATERNITY



FAIRMOUNT HOSPITAL

FOR UNMARRIED GIRLS

Est. 1909

Private sanitarium with certified obstetrician in charge. All adoptions arranged through juvenile court. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

Write for Information

HELEN AMOS

4911 East 27th St.

Kansas City, Mo.

WANTED—General Practitioner who can do some surgery, anaesthesia and obstetrics with a busy General Practitioner in Western Kentucky. Guarantee, and Commission Basis. Address: KSMA. Box, 620 South 3rd St., Louisville, Ky.

"The substitution of oral Neohydrin for parenteral meralluride was successfully accomplished in 97 per cent of 70 ambulatory clinic out-patients with chronic congestive heart failure."*

*Lawrence, W. E.; Kahn, S. S., and Riser, A. B.: South. M. J. 47:105, 1954.

98656



when your patient

complains that the pain

of neuritis is unbearable,

THORAZINE*

will help you

allay his suffering

'Thorazine' should be administered discriminately; and, before prescribing, the physician should be fully conversant with the available literature.

'Thorazine' acts not by eliminating the pain, but by altering the patient's reaction—enabling him to view his pain with a serene detachment. Howell and his associates[1] reported: "Several of [our patients] expressed the feeling that ['Thorazine'] put a curtain between them and their pain, so that whilst they were aware that the pain existed, they were not upset by it."

Smith, Kline & French Laboratories, Philadelphia

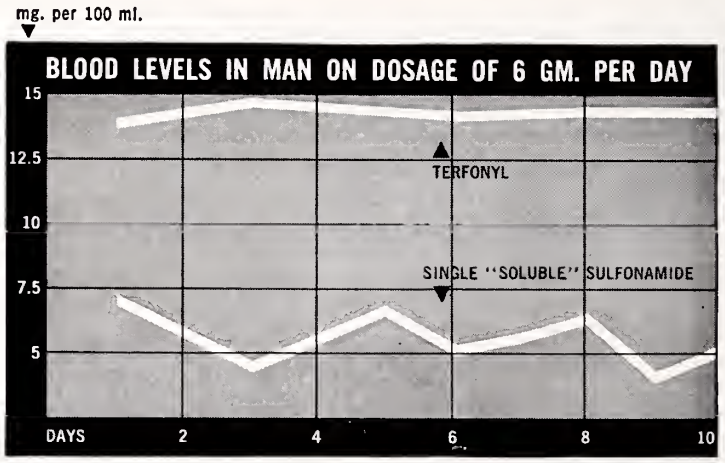
1. Howell, T.H., et al.: Practitioner *173*:172 (Aug.) 1954.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

maximum efficacy with minimum risk

Terfonyl

SQUIBB METH-DIA-MER SULFONAMIDES



– After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

Terfonyl is absorbed as well as single "soluble" sulfonamides, but is eliminated at a slower rate. For this reason, Terfonyl blood levels are much higher.

In experimental infections (Klebsiella, Pneumococcus, Streptococcus), Meth-Dia-Mer sulfonamides have been shown to be from three to four times more effective on a weight basis than single "soluble" sulfonamides.

Toxicity is minimal because normal dosage provides only one-third the normal amount of each sulfonamide. The body handles each component as though it were present alone, although therapeutic effects are additive.

Terfonyl Tablets, 0.5 Gm., bottles of 100 and 1000.
Terfonyl Suspension, 0.5 Gm. per 5 ml., pint bottles.

0.167 Gm. each of sulfamethazine, sulfadiazine and sulfamerazine per tablet or per 5 ml. teaspoonful of suspension.

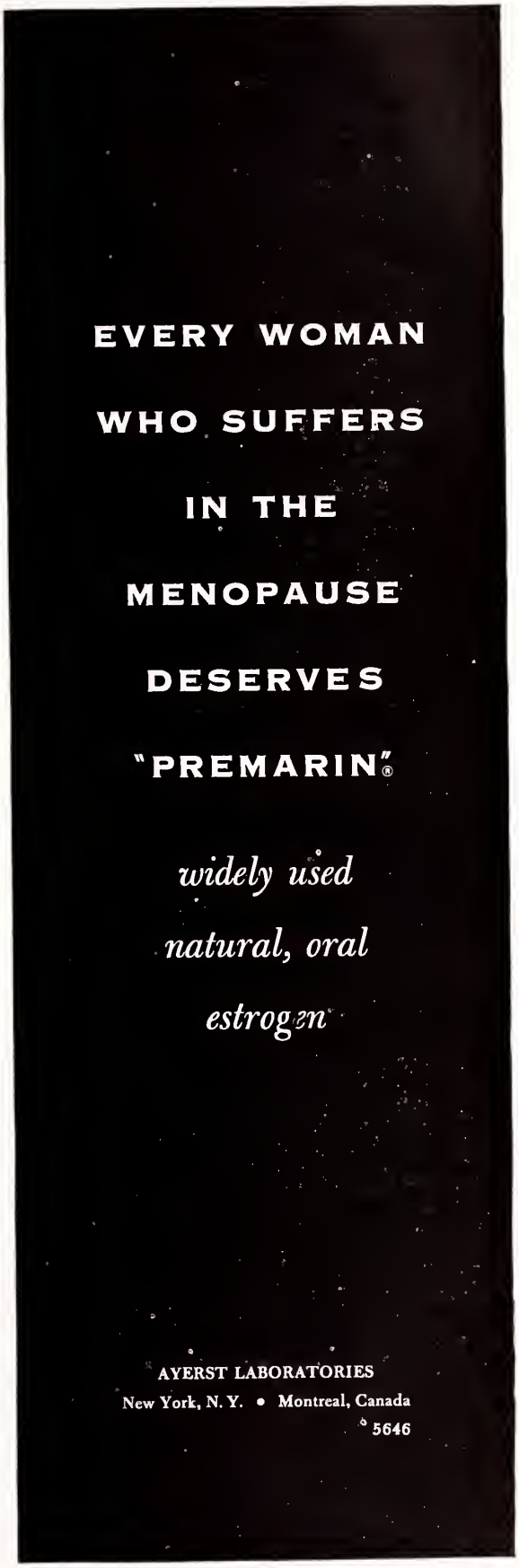
SQUIBB

'TERFONYL'® IS A SQUIBB TRADEMARK

BUYERS' GUIDE

Journal of the Kentucky State Medical Association, April, 1956

Ayerst Laboratories 381
Brayten Pharmaceutical Co.....317
Brown & Williamson Tobacco Co.....320
Burroughs Wellcome & Company.....311
Ciba Pharmaceutical Company 373
City View Sanitarium 364
Clearview Sanitarium 376
The Coca-Cola Company 324
Corn Products Refining Co 310
Crocker-Fels Company 324
Fairmount Hospital 378
Geigy Pharmaceutical Company.....377
Chas B. Knox Gelatine Company.....316
The Keeley Institute 376
K.S.M.A. (Want Ad) 378
Lakeside Laboratories 319, 366, 378
Lederle Laboratories 342, 343, 374
Eli Lilly & Company 326
W. R. Long (Insurance Co).....314
Louisville Medical Dental Business Bureau 376
Mead Johnson & Company.....384
Medical Protective Company 366
Muth Optical Company 376
New Castle Sanitarium 374
N. Y Polyclinic Med. Sch. & Hosp....370
Parke, Davis & Company.....302, 303
Pfizer Laboratories 309, 369
Physicians Casualty Ins. Co.....378
Pleasant Grove Hospital 382
Riker Laboratories 321
Schering Corporation 305
Schering Corporation .....Insert
Scientific Exhibits 344
Clayton L. Scroggins & Associates...373
G. D. Searle & Company.....363
Sharp & Dohme.....306, 307, 365, 375, 383
Smith, Kline & French.....379
Southern Optical Company.....374
R. E. Squibb & Company.....380
Upjohn Company 325, 367
U. S. Vitamin Corporation.....313
Wallace Laboratories 323
Wayside Hospital 376
White Cross Hospital 322
Winthrop Laboratories 371
Wyeth, Incorporated 315, 382





TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Members of the American Hospital Association and National Association of Private Psychiatric Hospitals

Five modern buildings, separate for men and women. Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD, Hospital Administrator

J. F. HALLER, Manager

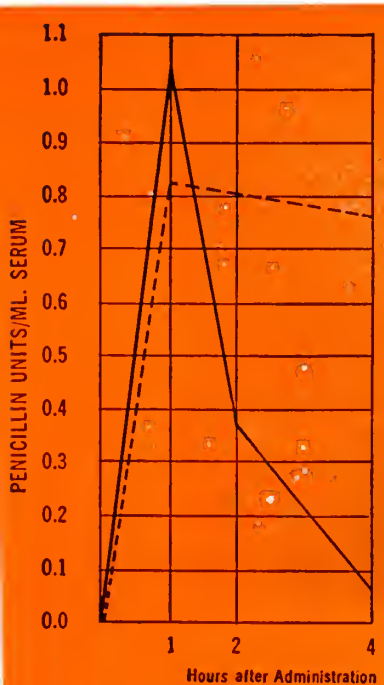
Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M. D., Neuropsychiatrist Medical Director

T. J. SMITH, M. D., Associate

Now! Palatable Oral Suspension Gives Higher, Faster Blood Levels than Twice the Dose of Injected Procaine Penicillin



This ready-mixed, stable, and pleasantly flavored suspension is supplied as follows: PEN•VEE•*Suspension*, 300,000 units per 5-cc. teaspoonful, bottles of 2 fl. oz. Also available PEN•VEE•*Oral* Tablets, 200,000 units, scored, bottles of 36; 500,000 units, scored, bottles of 12.

PEN·VEE*·*Suspension*

Benzathine Penicillin V Oral Suspension

ORAL PENICILLIN WITH *INJECTION* PERFORMANCE

Wyeth®
Philadelphia 1, Pa.

*Trade

All the benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress



Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra' are designed to help the physician cope with the problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids prednisone and prednisolone. Each Multiple Compressed Tablet is specifically formulated as a "tablet within a tablet" to provide stability and to release in sequence antacid and anti-inflammatory components.

NEW

'Co-Hydeltra'

Prednisolone Buffered

and

'Co-Deltra'

Prednisone Buffered

MULTIPLE COMPRESSED TABLETS

Supplied: Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra', each containing 5 mg. prednisone or prednisolone, 300 mg. of dried aluminum hydroxide gel, U.S.P., and 50 mg. of magnesium trisilicate, U.S.P., bottles of 30 tablets.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

'Co-Deltra' and 'Co-Hydeltra' are the trademarks of MERCK & CO., INC.



New...improved...

"instant"

Olac®

Powdered high protein formula

is easier to use

New, improved Olac dissolves instantly with water... makes a smooth, good-tasting formula with the briefest shaking or stirring.

...provides satisfying, growth-promoting feedings for

- full term bottle-fed babies
- prematures
- supplementary feedings of breast-fed babies

Olac's milk protein content is exceptionally generous. Its fat is a single highly refined vegetable oil. Curd tension is now reduced practically to zero.

Mead products and services are designed to help you in the varied phases of infant feeding

MEAD SYMBOL OF SERVICE IN MEDICINE

MEAD JOHNSON & COMPANY, EVANSVILLE 21, INDIANA, U.S.A.

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION

In this issue:

Pediatric Anesthesia
Cancer of the Genitourinary Tract
Anticoagulants in Myocardial Infarctions

See table of content page 388

KSMA
Annual Meeting
Sept. 18-20, 1956

VOLUME 54 • NUMBER 5 • MAY 1956

good medicine for sick youngsters



Suspension

Chloromycetin® Palmitate

pleasant-tasting Chloromycetin for pediatric use

Your young patients won't hit the war path at medication time when the prescription calls for SUSPENSION CHLOROMYCETIN PALMITATE. Its appealing custard flavor rates it as "good medicine" with the most rebellious braves.

Good medicine, too, for a wide variety of infections in infancy and childhood, CHLOROMYCETIN (chloramphenicol, Parke-Davis) affords rapid recovery and speedy convalescence.

Because of its liquid form, dosage of SUSPENSION CHLOROMYCETIN PALMITATE is easily adjusted. That it needs no refrigeration is an additional convenience to every harassed mother.



CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

supplied: SUSPENSION CHLOROMYCETIN PALMITATE, containing the equivalent of 125 mg. of Chloromycetin in each 4 cc., is available in 60-cc. vials.

MEDICAMENTA VERA

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

50027

The JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR PRO TEM: W. B. TROUTMAN, M. D. MED. EDITORIAL EDITOR: S. A. OVERSTREET, M. D.
MANAGING EDITOR: J. P. SANFORD BOOK REVIEW EDITOR: WALTER S. COE, M. D.
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D. ORGANIZATION EDITOR: BARBARA N. MORGAN
CASE DISCUSSIONS EDITOR: J. C. BELL, M. D. PUBLISHER: GIBBS-INMAN, LOUISVILLE

ADVISORY COMMITTEE TO THE EDITOR

Richard J. Rust, M. D. Guy Aud, M. D., Chairman James E. Hix, M. D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1958	Term Expires July 1, 1957	Term Expires July 1, 1956
Henry B. Asman, M.D.	Carey C. Barrett, M.D.	Everett H. Baker, M.D.
Richard Elliott, M.D.	Joe Bush, M.D.	John L. Dixon, M.D.
Rankin Blount, M.D.	Allen E. Grimes, M.D.	George G. Greene, M.D.
Marion F. Beard, M.D.	Richard F. Grise, M.D.	R. Arnold Griswold, M.D.
Glenn Bryant, M.D.	Billy Keller, M.D.	O. Leon Higdon, M. D.
Douglas Scott, M.D.	A. J. Miller, M.D.	James M. Keeton, M.D.
William C. Buschemeyer, M.D.	Robert Reeves, M.D.	Frank Moore, M.D.
Harry D. Abell, M.D.	Charles R. Yancey, M.D.	Alvin C. Poweleit, M.D.

Editorial and Business Offices, 620 S. Third St., Louisville, Kentucky

Subscription $8.00 per year Single Copy .80

Contents

SCIENTIFIC ARTICLES

PRESENT CONCEPTS OF ABNORMALITIES IN HEMOGLOBIN STRUCTURE
J. Douglas Ruff, M. D.,....411

PEDIATRIC ANESTHESIA, F. Hays Threlkel, M. D.,....414

CANCER OF THE GENITOURINARY TRACT, Peter Scardino, M. D.,....418

THE INDUCTION OF LABOR WITH ITS INDICATIONS AND COMPLICATIONS THAT MAY ARISE FROM THE USE OF PITUITARY EXTRACT AND PITOCIN
Julian Cole, M. D.,....421

A STUDY OF TUBERCULOSIS CAVITIES BY CONTRAST MEDIA AND OTHER METHODS, Oren Beatty, M. D.,....424

ANTICOAGULANTS IN MYOCARDIAL INFARCTIONS, Stuart Graves, M.D. 431

CASE DISCUSSIONS 435

THE END OF AN ERA....437

EDITORIALS

FROM THE EDITOR....439

THE CHANGING FACE OF TUBERCULOSIS....439

ADOLESCENT ADULTS....440

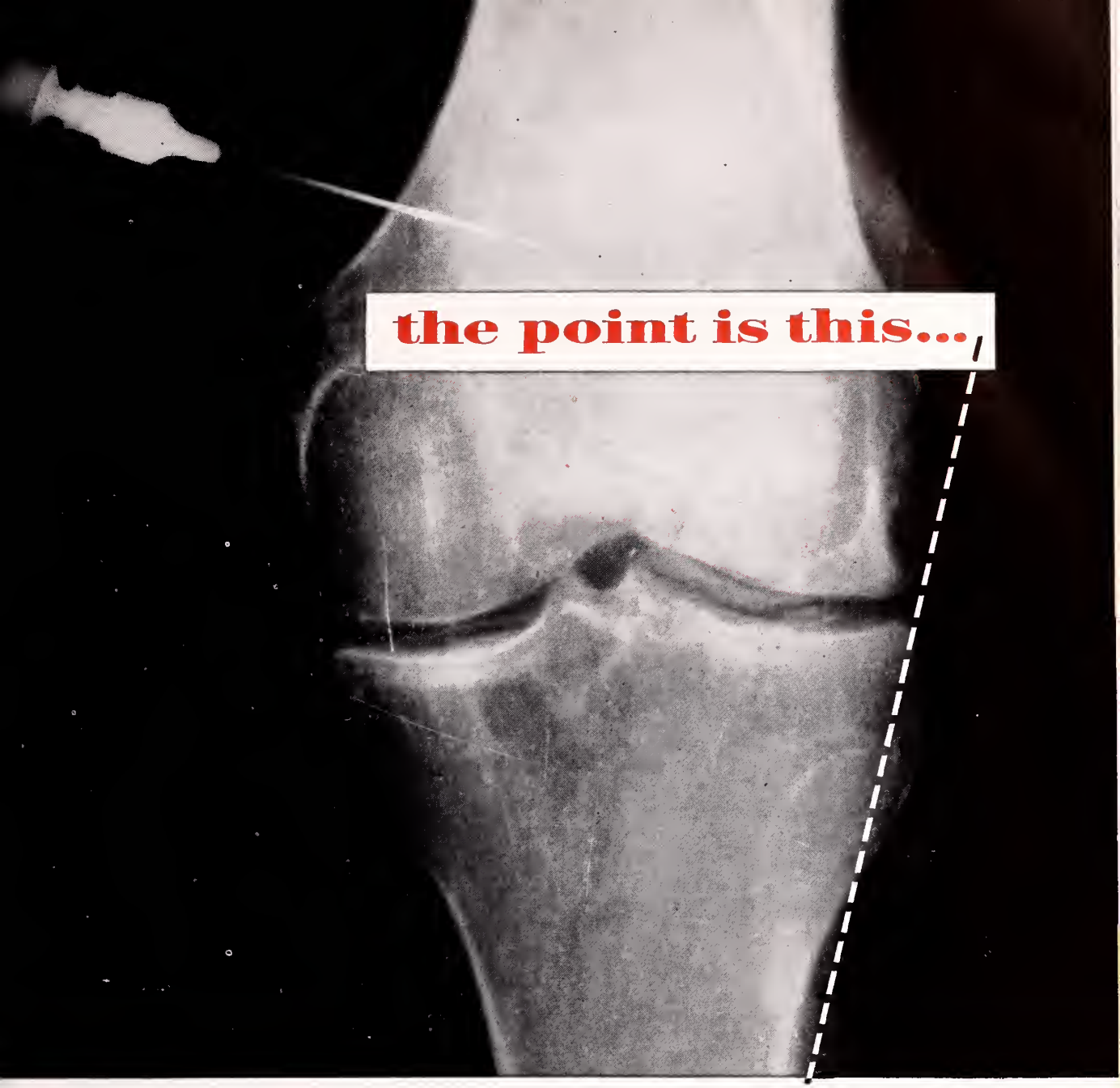
ORGANIZATION SECTION

Dr. Gaither Reports on Annual Meet....441
AMA President-elect Speaks at CSOC....441
Hospital Accreditation Rules Listed....443
Dr. Hess Speaks at Senior Day Meet....443
Commencement P-G Course Scheduled...444
Architects Named for UK Med School...444
FDA Says Hoxsey Treatment is Hoax....445
Louisville Medical Center Discussed....445
Gov. Chandler Speaks at KPHA Meeting..445
Sixth District MDs Meet March 13....446
Dr. Goodman is 'Family MD of Year'....446
Fulton's Dr. David Jones Honored....446

REGULAR DEPARTMENTS

President's Page 392, In the Books 396, Washington News Digest 402, News Items 451,

Second Class Mail privileges authorized at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.



HydroCortone® -T B A

(HYDROCORTISONE TERTIARY-BUTYLACETATE, MERCK)

gives the arthritic patient more days of freedom from joint symptoms—in many patients the anti-rheumatic effect persists 2 to 10 times longer than after injection of hydrocortisone acetate. Its action is local and without systemic effect.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

SUPPLIED: SALINE SUSPENSION HYDROCORTONE-TBA—25 MG./CC., VIALS OF 5 CC.

Meat...

and the Rehabilitation of Protein Depleted Patients

Although the recommended daily allowance of one gram of protein per kilogram of body weight is adequate for the average healthy adult,[1] greater amounts may be needed in the rehabilitation of patients depleted in protein after severe infections, mechanical trauma, burns, or extensive surgery.[2] Protein needs for tissue regeneration during convalescence are high.

To speed rehabilitation of the protein depleted patient, top quality protein and calories should be given in generous quantity.[2] However, a high protein intake, 130 grams daily, at best induces a slow response.[3] Intakes at 3 or 4 times that level may produce considerably more rapid gain in weight, strength, and morale.[4,5] If mastication and swallowing are difficult, canned strained meats—such as used in infant feeding—may be used to advantage in the high protein diet.[2]

Lean meat, outstanding in contained top quality protein, may well be made the keystone of the high protein diet. Its abundance of vitamin B complex and essential minerals—iron, phosphorus, potassium, and magnesium—adds to its therapeutic value. Important also are its appetite appeal, its easy digestibility, and its virtual freedom from allergenic properties.

1. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953.
2. Co Tui: Review: The Fundamentals of Clinical Proteinology, J. Clin. Nutrition *1*:232 (Mar.-Apr.) 1953.
3. Keys, A.; Brozek, J.; Henschel, A.; Mickelsen, O., and Taylor, H. L.: The Biology of Human Starvation, Minneapolis, Univ. of Minnesota Press, 1950.
4. Burger, G.C.E.; Drummond, J.C., and Sandstead, H.R.: Malnutrition and Starvation in Western Netherlands, The Hague General State Printing Office, 1948, Part II, p. 91.
5. Co Tui; Kuo, N.H.; Chuachiaco, M., and Mulholland, J.H.: The Protein Depletion (Hypoproteinia) Syndrome and Its Response to Hyper-Proteinization, Anesth. & Analg. *28*:1 (Jan.-Feb.) 1949.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago... Members Throughout the United States

Reduces Muscular Tension

Equanil®

MEPROBAMATE

(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

Licensed under U.S. Patent No. 2,724,720

Electromyography shows decisive response



Electromyographic study of neuromuscular hyperactivity in 42-year-old male with anxiety-tension syndrome. A, Before EQUANIL; action potential of high amplitude and frequency. B, After one week of ambulatory treatment with EQUANIL; showing definite reduction in tension, greater ability to relax, and marked improvement in muscular coordination. C, Point where patient makes effort to relax.[1]

The remarkable effectiveness of EQUANIL may be demonstrated in two ways. One is by its ability to relieve muscle spasm and neuromuscular tension.[1] The second is by its ability to relieve mental tension and anxiety.

Usual dosage: 1 tablet t.i.d. The dose may be adjusted either up or down, according to the clinical response of the patient.

Supplied: Tablets, 400 mg., bottles of 50.

1. Dickel, H.A., et al.: West. J. Surg., April, 1956.

anti-anxiety factor with muscle-relaxing action . . . relieves tension

Wyeth®

Philadelphia 1, Pa.

*Trademark



message from the President

The corporate practice of medicine is rapidly becoming a torrid issue. At the moment we have not resolved its proper definition. But regardless of the final definition, there is now being injected into the distribution of medical services, a third party—between the physician and the patient.

This means that the federal, state, county or city government—the insurance companies—the labor unions — the group doctors hiring for salary younger physicians — the hospitals — business groups—Blue Shield—and others are bargaining with future patients for prepaid fees to supply necessary medical care if, as and when needed.

The pressure of this thing has been mounting ever since Henry Ford established his hospital in Detroit 30 years ago and the Mayos organized their clinic with large salaries paid to their early men, the profit going into the finally great Mayo Foundation.

Do we wish this trend to become the real pattern of practice? It may well be if 'laissez faire' is to be the attitude we take as a Kentucky State Medical Association.

If we do not wish it, what steps are necessary to change or completely block this corporate practice?

You think it over, please. Bring out in papers, letters, resolutions, discussions and actions the various plans which may be reasonable and right.

We make no suggestions here editorially, yet. Our thinking is a bit advanced and would require much readjustment of personal freedom within our great association. Therefore we will welcome all ideas and thoughts about the matter of corporate practice.

Gant Gaither

GANT GAITHER, M.D.

Upjohn

Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

Cortef* *tablets*

Supplied:

5 mg. tablets in bottles of 50
10 mg. tablets in bottles of 25, 100, 500
20 mg. tablets in bottles of 25, 100, 500

*REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF HYDROCORTISONE (COMPOUND F)

The Upjohn Company, Kalamazoo, Michigan



Combat the debilitating effects of aging

GYNETONE REPETABS

Combined estrogen-androgen therapy provides the steroid support necessary for maximum physical and mental function in both males and females who would enjoy vigorous living in the years beyond 60. With GYNETONE REPETABS, optimally balanced estrogen-androgen, increased vitality as well as elevation of mental and emotional levels often follow therapy and help to keep the aging patient a productive and useful member of society.

also valuable in: osteoporosis • protein depletion • menopause

two strengths for individualized therapy

GYNETONE REPETABS ".02": Ethinyl Estradiol U.S.P. 0.02 mg. plus 5 mg. Methyltestosterone U.S.P.

GYNETONE REPETABS ".04": Ethinyl Estradiol U.S.P. 0.04 mg. plus 10 mg. Methyltestosterone U.S.P.

GYNETONE,® combined estrogen-androgen.
REPETABS,® Repeat Action Tablets. GT-J-62-256











unchanged life

in the changing years

two strengths

0.02 mg. ethinyl estradiol plus 5 mg. Methyltestosterone U.S.P.

0.04 mg. ethinyl estradiol plus 10 mg. Methyltestosterone U.S.P.

GYNETONE,® combined estrogen-androgen.

REPETABS,® Repeat Action Tablets.

GT-J-61-256



standard for therapeutic convenience

daylong relief from a single dose

CHLOR-TRIMETON® REPETABS 8 and 12 mg.
PRANTAL® REPETABS 100 mg.
GYNETONE® REPETABS ".02" and ".04"

CHLOR-TRIMETON® Maleate, brand of chlorprophenpyridamine maleate.
PRANTAL® Methylsulfate, brand of diphemanil methylsulfate.
GYNETONE,® combined estrogen-androgen.
REPETABS,® Repeat Action Tablets.

M-J-62-356



little

low to win friends ...



The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

15¢ Bottle of 24 tablets (2½ grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION
of Sterling Drug Inc.
1450 Broadway, New York 18, N. Y.



SURGERY IN WORLD WAR II; VASCULAR SURGERY: from the Medical Department of the United States Army. Edited by Daniel Elkin, M.D., and Michael DeBakey, M.D.: Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.: $4.25.

An entire volume is devoted to a reasonably complete accounting of the complications which followed combat incurred vascular injuries in casualties evacuated to the Zone of the Interior as well as an accounting of the peripheral vascular disorders observed in Army personnel during World War II. Edited by two surgeons whose achievements in vascular surgery are well known, Daniel C. Elkin, M.D., Michael E. DeBakey, M.D., the 16 chapters in this book are written by eight authorities in the field of vascular disease and vascular surgery.

Extremely worth-while are the sections on evaluation of the vascular status in the traumatic and non-traumatic lesions of the blood vessels, acute battle incurred injuries, and technical considerations in the exposure of blood vessels. Considerable emphasis is understandably placed on a detailed physical examination of these patients. Various tests, such as skin temperature determinations, oscillometry, venous pressure determinations, and circulation times, which required special equipment, for the most part proved ancillary and revealed little that could not be elicited by physical examination. Arteriography during this period was performed using thorotrast or diodrast. Two of the three vascular centers used arteriography occasionally or not at all.

When compared today with the increasing use of artery homografts and vessel prostheses, the small number of cases of arterial injury and arteriovenous fistula in which repair during World War II was accomplished with the use of vein grafts and prosthetic devices reflect the progress made in this field since that time. Anticoagulants were used sparingly. Both heparin and dicumarol were available.

A major portion of the volume is devoted to arteriovenous fistula. This is quite understandable in dealing with military surgery but the subject is discussed out of proportion when compared with everyday civilian experiences.

Of the 3,778 patients with vascular conditions observed at the vascular centers during World War II, 7.3 per cent had thromboangiitis obliterans. The importance of permanent abstinence from tobacco with this disease was emphasized at length. Arteriosclerosis of the peripheral vessels sufficient to produce symptoms was reported in 55 patients.

Valuable bibliographic references are listed throughout the book, 139 alone in the chapter on acute arterial injuries.

This book should be of interest to any physician interested in vascular disease and is particularly recommended for those who occasionally deal with acute vascular injuries.

J. Herman Mahaffey, M.D.

CHRISTOPHER'S TEXTBOOK OF SURGERY: Editor—Loyal Davis, M. D.: Sixth Edition: 1484 Pages: $15.50: W. B. Saunders Co.

The new Davis-Christopher's "Textbook of Surgery" is the sixth edition of one of several such standard inclusive American textbooks. The present edition is almost completely new. As a matter of fact, except for the name on the cover and the fact that the 35 chapters have been written by 87 nationally known authorities, the text is completely new rather than merely re-written or re-edited.

The usual textbook of surgery is either written by one man, with the assistance of a very few co-authors, or is written as this one, with a different author for each chapter or sub-chapter. The deficiency of the former type of book is that it is limited by the experience, knowledge, and opinions of the few contributors. In the latter case, it is likely to be a discontinuous hodgepodge of surgical information. Neither of these deficiencies is true of the Davis-Christopher text. Dr. Davis has completely rearranged the chapter outlines so that there is just as much continuity as if the book were written by a single author, and the chapters are neatly fitted together.

The text is complete enough, including sub-specialties of surgery, so that it might adequately serve as almost the sole text in the surgical field for a medical student. For the general practitioner or internist who wishes to keep abreast of the latest in all branches of surgery, not only for his own interest, but so that he may intelligently discuss surgical procedures with surgical consultants, it should prove invaluable. For the general surgeon or surgical specialist, it gives excellent review of modern surgical thought and practice in all fields of surgery, including his own. In summary, it may be said that I cannot think of a practitioner who would not benefit from having this volume in his library.

R. Arnold Griswold, M.D.

All the benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress



Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra' are designed to help the physician cope with the problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids prednisone and prednisolone. Each Multiple Compressed Tablet is specifically formulated as a "tablet within a tablet" to provide stability and to release in sequence antacid and anti-inflammatory components.

NEW

'Co-Deltra'

Prednisone Buffered

MULTIPLE COMPRESSED TABLETS

and

'Co-Hydeltra'

Prednisolone Buffered

Supplied: Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra', each containing 5 mg. prednisone or prednisolone, 300 mg. of dried aluminum hydroxide gel, U.S.P., and 50 mg. of magnesium trisilicate, U.S.P., bottles of 30 tablets.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

'Co-Deltra' and 'Co-Hydeltra' are the trademarks of MERCK & CO., INC.

SOCIALIZED MEDICINE

May never come, but . . . Socialized Insurance is here to stay, and it has created a sizable Estate Handicap against the physician.

In the case of a young doctor with young children, this economic penalty may be as high as $40,000.00

But there is a solution, and the cost is no greater than the Social Security Tax. Write now for complete information

---

W. R. LONG & ASSOCIATES
1534 Bardstown Road—Louisville, Ky.

Without obligaiton to me I would like to have more information about the solution to the Social Security problem of the young doctor. I am in good health and was

born .....
Month Day Year

Name .....

Address .....

HAND SURGERY IN WORLD WAR II: Edited by Sterling Bunnell, M. D.: Office of the Surgeon General, Department of the Army. 419 pages: 1955. $3.75.

This book is edited by Sterling Bunnell, M.D., who in 1944 was appointed a special civilian consultant to the Secretary of War to develop, guide and integrate the field of hand surgery in military hospitals.

The book has 419 pages. There are 13 authors, each of whom tells his own story and recounts his activities in the military center to which he was assigned. There is some repetition of subject material, which actually adds to the value of the book since it presents a more composite picture.

All serious hand injuries during World War II were concentrated in nine General Hospitals. The management of hand surgery at these centers was directed by men with special training in hand surgery.

To quote Dr. Bunnell, "Hand surgery should be carried out as a special service. The surgeon responsible for the hand should control the composite situation, unhampered by anatomic limitations, so that he might approach the problem from the functional standpoint. The hand surgeon must work from the elbow down in three overlapping specialties: plastic, orthopedic and neurosurgery. The hand is so intricate in structure that if dissected in turn by three different specialists it is likely to be wrecked beyond repair. The bones, joints, muscles, tendons, nerves and skin are all parts of a composite mechanism in the function of the hand and they can best be repaired by the surgeon who assumes responsibility for the whole. Hand surgery is an area speciality, not a tissue special."

This theme, quoted from Dr. Bunnell, carries through the book. Optimum time for surgery, technique of operative procedures, correct splinting and rehabilitation are described for many types of injuries.

Experience taught that the early closure of injuries to hands is essential for recovery of good function. The initial therapy had to be performed in the forward areas. Since several days elapsed prior to evacuation of these injured patients to a hand center, most of the text is concerned with reconstructive surgery of the hand rather than definitive primary care of the wound.

Two hundred and twenty three illustrations are utilized to portray splints, operative procedures, and results.

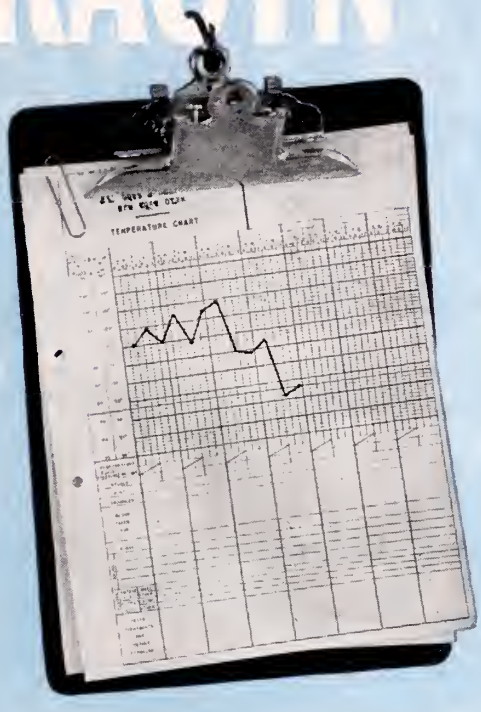
The book is an excellent adjunct to the library of physicians who frequently encounter hand injuries.

Harold E. Kleinert, M.D.

clinical advantages with

TETRACYN®

BRAND OF TETRACYCLINE



- rapid absorption and distribution to all parts of the body
- prompt, broad-spectrum action against infections caused by gram-positive and gram-negative bacteria, spirochetes, certain large viruses and protozoa
- minimal incidence of adverse reactions
- available in a wide selection of convenient dosage forms for oral, parenteral or topical use

Tetracycline the nucleus of modern broad-spectrum activity discovered and identified by Pfizer scientists

Pfizer

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, N. Y.

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

looked over often...

the patient with nonspecific rheumatism

NOW—thoroughgoing relief with

NEW SIGMAGEN TABLETS



combining

Prednisone	0.75 mg.	—best of the new
Acetylsalicylic acid	325 mg.	—best of the old
Ascorbic acid	20 mg.	
Aluminum hydroxide	75 mg.	

antirheumatic • anti-inflammatory • analgesic • supportive

Combined effectiveness of the antirheumatic agents in SIGMAGEN permits maintenance of clinical relief at minimal dosages.

SIGMAGEN,* brand of corticoid-analgesic compound.
*T. M.

Schering

56-J-66



WASHINGTON NEWS DIGEST



Washington, D. C.—Among a growing list of health measures receiving active consideration this Congress are two bills that have very good chance of becoming law before adjournment this summer. That both measures have bi-partisan support is an important factor in this election-charged year.

Most advanced in the legislative process, having passed the Senate before the Easter recess, is the national morbidity survey proposal. The other bill, which also originated in the Senate, is the National Library of Medicine plan. Both are indorsed by the Eisenhower Administration.

There has been no national study of the extent of sickness and disability since the rather inadequate survey made in 1936 by the WPA. A series of special and continuing surveys under auspices of the U. S. Public Health Service, accordingly will fill "a very great need," Senator Hill, one of the bill's sponsors, informed the Senate.

Secretary Folsom of the Department of HEW describes the lack of morbidity data as "woeful." Nationwide data on the incidence, cause and duration of sickness and disability are basic, Mr. Folsom has pointed out, to efforts in improving voluntary health insurance.

The Senate agreed and, after writing in an amendment that would assure the conduct of surveys on a non-compulsory basis, the bill passed without a dissenting voice. The measure then went to the House Interstate and Foreign Commerce Committee. The American Medical Association indorses the survey idea.

The National Library of Medicine bill sponsored by Senators Hill and John Kennedy is an outgrowth of one of the Hoover Commission recommendations. The medical task force proposed that the Armed Forces Medical Library be reconstituted as the National Library and placed under the Smithsonian Institution. The Hill-Kennedy bill differs from the Commission in one major respect: it would establish the Library as an independent agency.

Sentiment, meanwhile, has developed for placing the Library in the Department of HEW, under Public Health Service supervision. This was supported by the Administration, and the American Medical Association urged immediate start on construction. Almost two years ago, before the question arose of a National Library, the AMA House of Delegates foresaw the need for housing the Armed Forces Library in more adequate quarters.

The bill's sponsors pointed out that the AMA in June of 1954 had found that "the irreplaceable collections of the Armed Forces Medical Library are now housed in a 67-year-old building totally unsuitable for the purpose by reason of its inadequate size, poor state of repair, susceptibility to fire hazard and general inadaptability to efficient operations. . ."

Both Senators made this additional point: so long as it remains in the Defense Department, the Library simply cannot compete for funds against the needs and demands of those activities directly related to national defense.

A major development in the long legislative history of the House-approved bill to open up the social security system to cash disability payments was the testimony of Secretary Folsom to the Senate Finance Committee.

In a 3-hour appearance as the 101st and final witness, Mr. Folsom warned against enactment on the disability portion of the bill as well as the plan to lower the retirement age of women from 65 to 62.

Disability payments at age 50, Mr. Folsom declared, present "grave uncertainties" and "potential heavy costs to all social security taxpayers." A majority of the witnesses heard during the extended hearings opposed this section of the bill, H.R. 7225.

*** ***

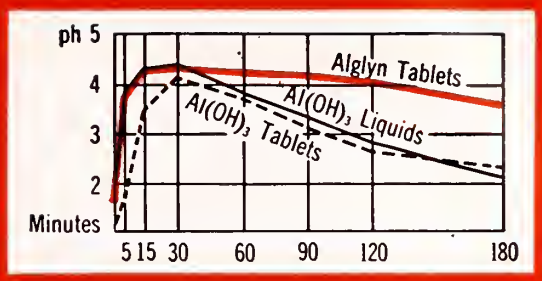
On the eve of the launching of the 1956 Cancer Crusade, the Food and Drug Administration issued its first public warning of this type in several years against the cancer treatment fostered by Harry M. Hoxsey. FDA said long and thorough study by it and the National Cancer Institute has produced "no scientific evidence that the Hoxsey treatment has any value in the treatment of internal cancer." FDA said Hoxsey operates clinics at Dallas, Tex., and Portage, Pa.

*** ***

NOTES:

Surgeon General Leonard Scheele has been confirmed by the Senate for a third 4-year term as head of the U.S. Public Health Service . . . Chairman Priest of the House Interstate and Foreign Commerce Committee has introduced a bill transferring from the Civil Aeronautics Board to the Civil Aeronautics Authority all medical aspects of civil aviation, including pilot examinations. It also authorizes a research program for the proposed Office of Civil Aviation Medicine . . . PHS says the production of the Salk poliomyelitis vaccine is improving. It is now practical, added PHS, for doctors to use their available vaccine for first injections, and to count on receiving new supplies by the time second shots are due . . . PHS Division of International Health, Washington 25, D. C. has a number of openings for physicians in foreign posts.

Announcing Revision of N.N.R. Monograph for



ALGLYN®

dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayton PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

All the



Multiple Compressed Tablets 'Co-Deltra' and 'Co-Hydeltra' are unique among the dosage forms of the newer steroids, because they are specifically designed as a tablet within a tablet to provide stability and to release in sequence, antacid and anti-inflammatory agents . . .

1. the outer layer of antacids (aluminum hydroxide gel and magnesium trisilicate) comes into contact with the gastric mucosa first . . . and after it is completely dissolved . . .

2. *the hitherto intact inner core* containing the anti-inflammatory agent (either prednisone or prednisolone) then begins to release its full therapeutic potential . . . and not before.

NEW

Multiple Compressed Tablets

'Co-Deltra'

Prednisone Buffered

benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress...

A reportedly higher incidence of gastric distress in patients receiving the newer steroids prednisone and prednisolone indicates the desirability of co-administering non-systemic antacids.[1]

To help the physician cope with this problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids . . . Multiple Compressed Tablets 'Co-Deltra' (Prednisone Buffered) and 'Co-Hydeltra' (Prednisolone Buffered) are now available.

'Co-Deltra' and 'Co-Hydeltra' are now available in bottles of 30 on your prescription. Each Multiple Compressed Tablet contains:

Prednisone or Prednisolone, 5 mg.; 300 mg. of dried aluminum hydroxide gel, U.S.P., and 50 mg. of magnesium trisilicate.

'Co-Deltra' and 'Co-Hydeltra' are trade-marks of Merck & Co., Inc.

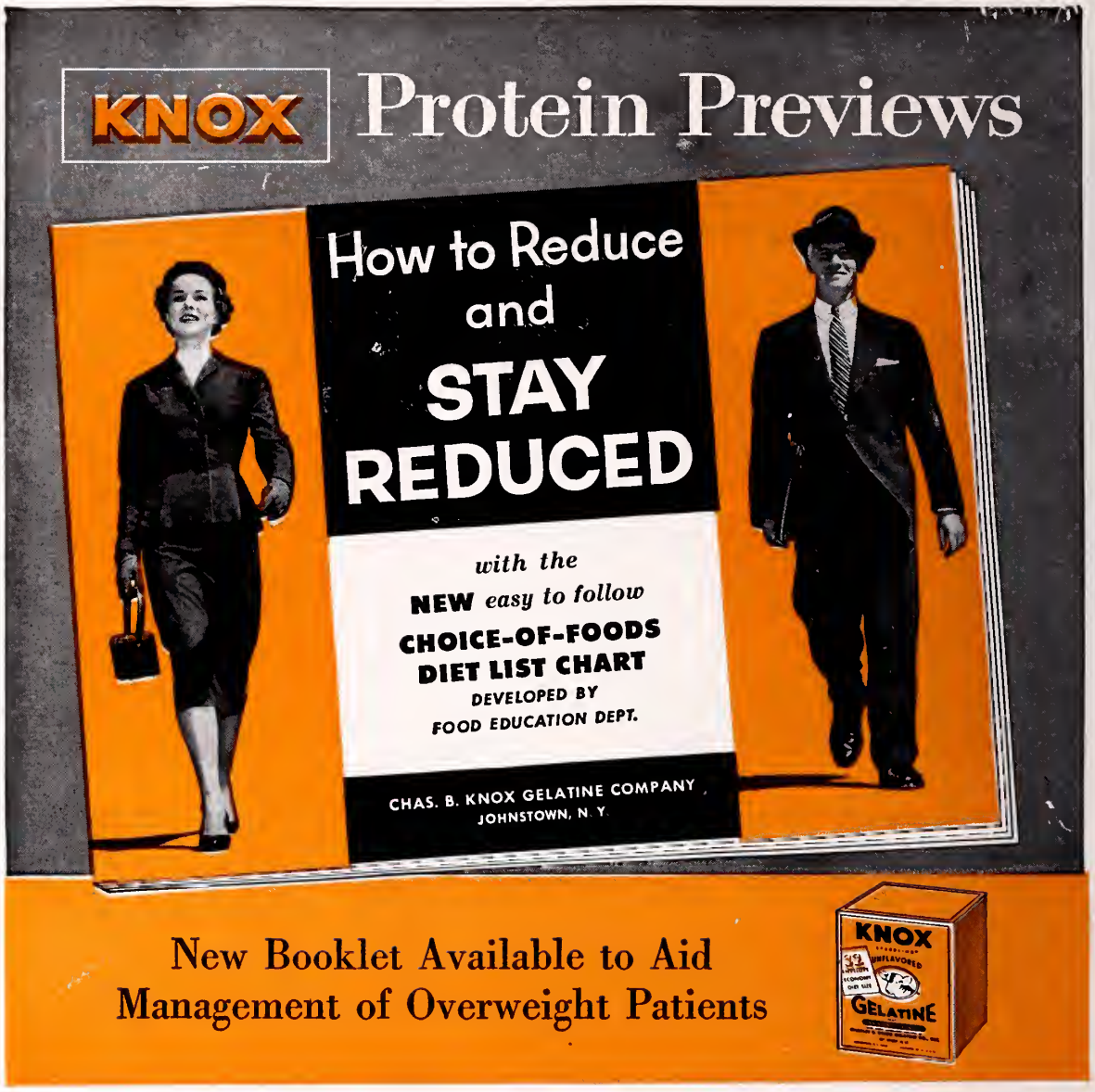
1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* **158**: 459, June 11, 1955.

'Co-Hydeltra'

Prednisolone Buffered

SHARP & DOHME

Philadelphia 1, Pa.
Division of Merck & Co., Inc.



The 1955 edition of the well-known Knox "Eat-and-Reduce" booklet eliminates calorie counting for your obese patients. This year's edition is based on the use of Food Exchange Lists[1] which have proved so accurate in the dietary management of diabetics. These lists have been adapted to the dietary needs of patients who must lose weight.

The first 18 pages of the new booklet present in simple terms key information on the use of Food Exchanges (referred to in the book as Choices). In the center, double gatefold pages outline color-coded diets of 1200, 1600, and 1800 calories based on the Food Exchanges. Physicians will find these diets easy to revise to meet the special needs of individual patients.

To help patients persevere in their reducing plans, the last 14 pages of the new Knox booklet are devoted to more than six dozen *tested*, low-calorie recipes. Please use the coupon below to obtain copies of the new "Eat-and-Reduce" booklet for your practice.

1. Developed by the U. S. Public Health Service assisted by committees of The American Diabetes Assn., Inc. and The American Dietetic Assn.

Chas. B. Knox Gelatine Co., Inc.
Professional Service Dept. S. J.-17
Johnstown, N. Y.

Please send me____copies of the new illustrated Knox "Eat-and-Reduce" booklet based on Food Exchanges.

your patient should not be endangered by fluid accumulation during "rest periods"

YOUR PATIENT NEEDS AN ORGANOMERCURIAL

When a diuretic must evoke acidosis to be effective, continued administration without dosage limitation results in refractoriness. Other diuretics may require interrupted dosage to avoid gastrointestinal irritation.

But the sustained diuresis achieved by the organomercurials never necessitates routine "rest periods" because of their mode of action.

TABLET **NEOHYDRIN®**

BRAND OF CHLORMERODRIN (16.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure **MERCUHYDRIN® SODIUM**
BRAND OF MERALLURIDE INJECTION

01256



DOCTORS EVERYWHERE NOW KNOW WHY

Viceroys Are Smoother



Professional men who have studied the microscopic analysis of the Viceroy filter now know why the Viceroy taste is smoother—never rough. Only Viceroy has 20,000 tiny filters in every tip—twice as many filters as the other two largest-selling filter brands. That is why Viceroys are smoother by far—never, never rough. That is why so many doctors now smoke and recommend Viceroys.

Yes, smoother taste because there are

TWICE AS MANY FILTERS IN EVERY VICEROY TIP

as the other two largest-selling filter brands!



Viceroy's exclusive filter is made from pure cellulose—soft, snow-white, natural!



in rheumatoid arthritis

continuing benefits

for successful corticosteroid therapy

METICORTELONE*

(PREDNISOLONE)

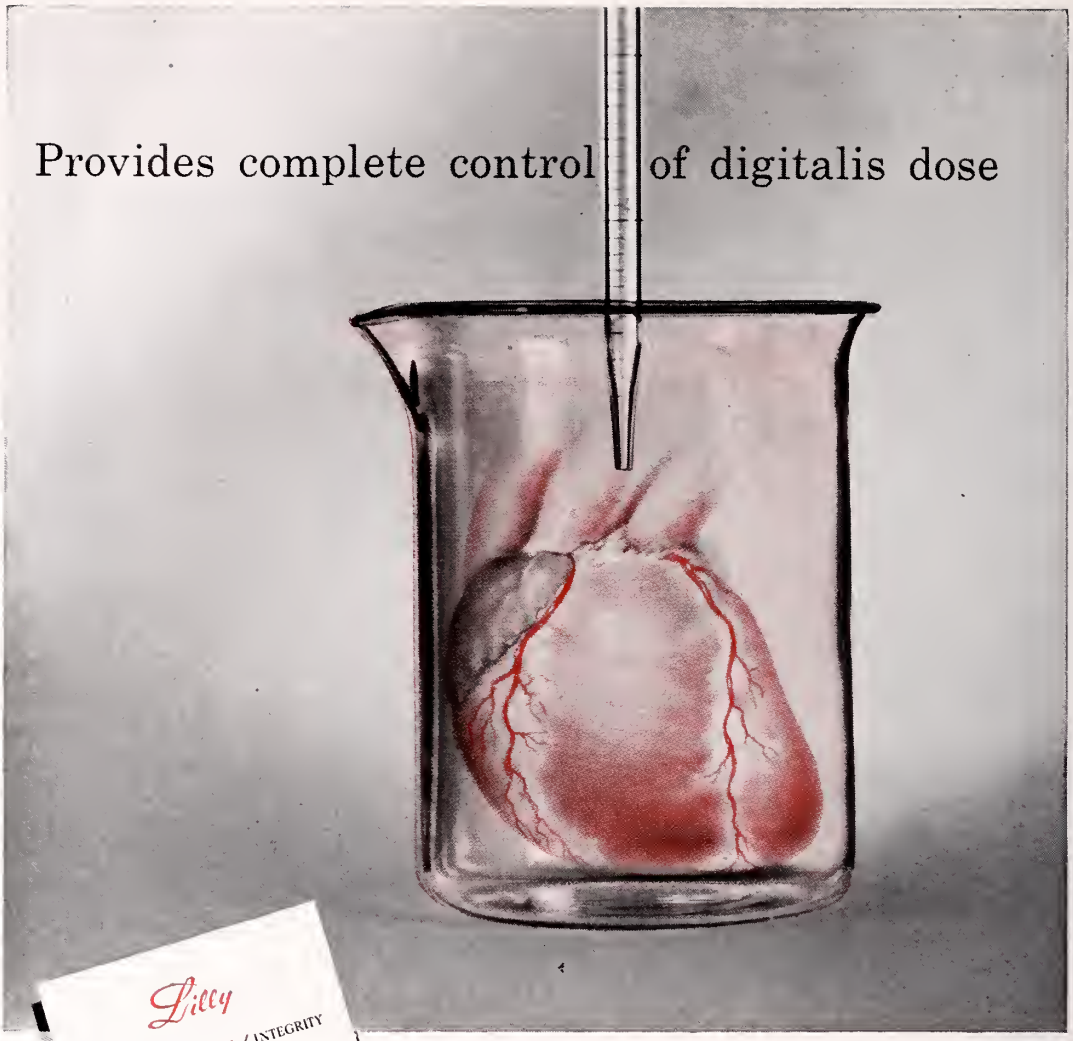
- therapy usually undisturbed by sodium retention, edema, weight gain
- excellent relief of arthritic pain, swelling, tenderness
- spares patients salt-poor diets
- up to 5 times as potent as hydrocortisone

Available as 1, 2.5, and 5 mg. tablets; 2.5 and 5 mg. capsules

METICORTELONE,* brand of prednisolone. *T. M. ML-J-66-256

Schering

Provides complete control of digitalis dose



Lilly

QUALITY / RESEARCH / INTEGRITY

666003

'Crystodigin'

(CRYSTALLINE DIGITOXIN, LILLY)

. . . . . permits accurate dosage titration to produce the maximum therapeutic effect

Available in scored tablets of 0.05 mg. (orange), 0.1 mg. (pink), 0.15 mg. (yellow), and 0.2 mg. (white); and in 1-cc. and 10-cc. ampoules, 0.2 mg. per cc.

Since initial digitalization and maintenance dosage must be carefully individualized, 'Crystodigin' fulfills the important requirements of a preferred digitalis. 'Crystodigin' is a crystalline-pure, uniformly potent single glycoside that is completely absorbed in the gastro-intestinal tract. With 'Crystodigin,' the maximum therapeutic effect can be safely determined by dosage titration in increments as small as 0.025 mg.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

80TH ANNIVERSARY 1876 • 1956

The JOURNAL of the

Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 MAY, 1956 NO. 5

PRESENT CONCEPTS OF ABNORMALITIES IN HEMOGLOBIN STRUCTURE*

J. DOUGLAS RUFF, M.D.
Lexington

THE PURPOSE of this discussion is to review the various hemolytic syndromes based on inherited abnormalities of hemoglobin structure. A single family study will serve to illustrate one of the syndromes. Conditions in which there is loss of oxygen transport capacity, such as methemoglobinemia, carboxyhemoglobinemia and sulfhemoglobinemia, will not be discussed.

The inherited hemolytic syndromes of main consideration were at an early date designated sickle cell anemia, Mediterranean anemia, and congenital hemolytic or spherocytic anemia. The numerous studies of red cell survival time by various technics demonstrated that the basic defect lay in the red cell itself. The study of the genetics of sickle cell disease culminated in Neel's hypothesis[1] that the sickling phenomenon is due to a gene which in single dose produces the sickle cell trait and in double dose, sickle cell disease. Mediterranean or Cooley's anemia probably is analagous. Study of the hemoglobin by various technics has been most helpful in establishing the pathogenesis of the various hemolytic syndromes.

As a protein hemoglobin has many properties for study. In 1936 Barcraft described the following ways in which fetal hemoglobin differs from normal adult hemoglobin: 1. It is more resistant to action of alkali. 2. It has a greater affinity for oxygen. 3. It is different spectroscopically. The presence of fetal hemoglobin in Cooley's anemia was suggested in 1948 by the use of alkali-denaturization methods and subsequently confirmed by a variety of methods, including paper chromatography, solubility of oxygenated hemoglobin, crystallography, spectrophotometry, fractional alkali denaturization, moving boundary electrophoresis, and most recently by paper electrophoresis.[2]

In 1949 Pauling and his colleagues[3] used the last mentioned technic in discovering hemoglobin S, the abnormal hemoglobin present in persons with sickle cell anemia and the sickle cell trait. The basic difference in S hemoglobin is that the net number of positive charges is greater in sickle cell hemoglobin than in normal hemoglobin. In addition, there is an increase in resistance to alkali denaturization.[4,5]

Pauling's work was probably the greatest stimulus in this field of investigation, as the principal of electrophoresis can be applied using relatively simple apparatus.

Filter Paper Electrophoresis

The word electrophoresis means "borne by electricity," and its special name has been given to the technic of separating molecular mixtures. When suspensions of molecules are placed in a fluid conduction system and subjected to an electric field, closely related molecules will migrate in the same direction. Whether or not one uses an elaborate apparatus such as that invented by Tiselius, a Swedish chemist, or a more simple one, it is possible to obtain a characteristic pattern and a quantitative separation of molecules. In order to have mobility, a substance must have a net charge,

*Presented at a regional meeting of the American College of Physicians.

and if a molecule contains equal numbers of acid and base groups, it may be made to acquire a net charge by suitable adjustment of pH.[6] In the more simple apparatus the particles move in a liquid that fills the spaces of a finely divided solid (filter paper) instead of the U-tube used in the Tiselius apparatus.

Subsequent to Pauling's work and the more widespread use of electrophoresis as a tool in investigating hemolytic syndromes, an ever widening spectrum of interrelated hemolytic syndromes became apparent (table 1).

Hemoglobin C.—In 1951 Kaplan, Zuelzer and Neel[7] identified a new inherited abnormality of hemoglobin. Pauling previously had shown that S hemoglobin has less anodic mobility than normal hemoglobin. The third abnormal hemoglobin C moves still less rapidly. This was first discovered in a patient who had inherited the combination of hemoglobin S gene and hemoglobin C gene, each in single dose. This hemolytic syndrome has been designated sickle cell hemoglobin C disease and is

Table 1
Abnormal Hemoglobin Syndromes

Disorder	Hemoglobin Type
Sickle cell trait	A + S
Sickle cell disease	S + F
Hemoglobin C trait	A + C
Hemoglobin C disease	C
Sickle cell-hemoglobin C disease	C + S (+F)
Hemoglobin D trait	A + D
Sickle cell-hemoglobin D disease	S + D
Thalassemia major	A + F
Sickle cell-thalassemia	S + A + F
Hemoglobin C-thalassemia	C + A (+F)
Hemoglobin G trait	A + G
Hemoglobin E trait	A + E
Hemoglobin E-thalassemia	E + F
Hemoglobin H disease (?)	H + (?)A
Hemoglobin I trait	I + A

demonstrated by the following case which I have observed during the past year.

The patient was a 19 year old Negro female. She was admitted to the hospital on June 21, 1954, with a chief complaint of "pain in the abdomen," which had begun at 6 a.m. The pain began in the back and radiated across the lower abdomen, and at the time of examination it was located mainly in the left lower quadrant.

The physical examination was negative except for abdominal tenderness. The laboratory findings were as follows: The erythrocyte count was 2,700,000. The hemoglobin was 7.1 gm. The leukocyte count was 16,050. The urinalysis was negative. A Kahn test for syphilis was negative.

A diagnosis of acute appendicitis was made. At surgery a normal appearing appendix was removed. Postoperatively the blood findings were re-examined, and it was noted that the blood smear was characterized by having a large number of target cells. Normoblasts were present also. A test for cold agglutinins was negative. The reticulocyte count was 3.8 per

Table 2*
Sickle Cell-Hemoglobin C Disease

Name	Age (yrs)	Sickle cell test†	Hemoglobin variety	Diagnosis
A. B., father	40	Positive	S + A	Sickle cell trait
M. B., mother	35	Negative	C + A	Hemoglobin C trait
W. B., brother	12	Negative	A	Normal
C. B., brother	16	Negative	C + A	Hemoglobin C trait
M. B., brother	17	Negative	A	Normal
O. B., propositus	18	Positive	S + C	Sickle cell-hemoglobin C

*The initial electrophoresis studies in this case were done in the laboratories of the Cleveland Clinic through the kindness of Dr. James S. Hewlett.

†Sodium metabisulfite was used as the reducing agent.

cent. A sickle cell preparation using the cover-slip method and also using sodium metabisulfite was positive. The patient was given 2,000 cc. of whole blood. Before dismissal from the hospital a sternal bone marrow aspiration was done, and the appearance of the bone marrow was consistent with increased red cell regeneration.

The parents of the patient were studied,

and it was found that, while the father was positive for the sickle cell trait, the mother was negative. The blood smear of the latter showed marked increase in the number of target cells present. A family study was made in order to determine what type of hemolytic syndrome the patient had, and the diagnosis of sickle cell hemoglobin C disease was made (table 2).

Hemoglobin D.—Itano[8] soon described a third hemoglobin abnormality designated "D," which is characterized by the electrophoretic mobility of S but which is not associated with sickling. It also has specific solubility characteristics.

Several investigators later discovered cases of hemoglobin C disease, the homozygous state present in persons who receive the hemoglobin C gene in double dose. Here there is no sickling, but usually there is an increase in the number of target cells present.[9] This hemolytic syndrome is indistinguishable clinically from the other related syndromes.

Hemoglobin G.—Another abnormal form designated "G" differs slightly in its speed of migration from S hemoglobin, and there is no associated sickling.[10] There has been no report of the homozygous state in the case of hemoglobin G.

Zuelzer and Kaplan were first to describe another new syndrome due to a combination of the genes for thalassemia and hemoglobin C.[11,12,13] The patient and his father were shown to be carriers of the C trait; the mother and several siblings, of the thalassemia gene. The patient had a severe chronic hypochromic microcytic anemia.

Hemoglobin E.—Sturgeon and his colleagues[14] described hemoglobin E, which does not sickle; under alkaline conditions it migrates slowly at a rate comparable to hemoglobin C, while at an acid pH it migrates at a rate similar to hemoglobin S. Its interaction with thalassemia trait was demonstrated to produce hypochromic anemia clinically resembling thalassemia major. Other cases have been described subsequently.

Sturgeon and his co-workers[15] described the syndrome resulting from combination of hemoglobins S and D, and several other similar cases and families have been studied.

Hemoglobins H and I.—Rigas and his colleagues[16] have reported the existence of hemoglobin H in two siblings with hemolytic anemia. Hemoglobin H exhibits a migratory rate at pH 8.6 in excess of that of hemoglobin A. Another abnormal form more recently described,[71] hemoglobin I, exists in combination with A without hematologic abnormalities. The paper electrophoretic migratory rates of hemoglobins H and I at pH 8.6 are indistinguishable, but specific differences are apparent at pH 6.5.

Summary

To date seven abnormalities of hemoglobin or "hemoglobinopathies" have been described. Paper electrophoresis has become an important diagnostic tool for the study and diagnosis of anemia, and has contributed greatly to our knowledge of certain inherited hemolytic syndromes. These hemolytic syndromes, along with the underlying hemoglobinopathies, have been briefly reviewed. A case of sickle cell hemoglobin C disease is presented.

References

1. Neel, J. V.: The inheritance of sickle cell anemia. Blood 6:389, 1951.

2. Sturgeon, Phillip, Itano, Harvey A., and Bergren, William R.: Genetic and biochemical studies of 'intermediate' types of Cooley's anaemia. Brit. J. Haematol. 1:264, 1955.

3. Pauling, L., Itano, H. A., Singer, S. J., and Wells, I. C.: Sickle cell anemia, a molecular disease. Science 110:543, 1949.

4. Singer, K., Chernoff, A. I., and Singer, L.: Studies on abnormal hemoglobins. I. Their demonstration in sickle cell anemia and other hematologic disorders by means of alkali denaturation. Blood 6:413, 1951.

5. Singer, K., Chernoff, A. I., and Singer, L.: Studies on abnormal hemoglobins; their identification by means of the method of fractional denaturation. Blood 6:429, 1951.

6. Consden, R., and Stanier, W. M.: Ionphoresis of sugars on papers and some applications to the analysis of protein polysaccharide complexes. Nature 169:783, 1952.

7. Kaplan, E., Zuelzer, W. W., and Neel, J. V.: A new inherited abnormality of hemoglobin and its interaction with sickle cell hemoglobin. Blood 6:1240, 1951.

8. Itano, H. A.: A third abnormal hemoglobin associated with hereditary hemolytic anemia. Proc. Nat. Acad. Sc. 37:775, 1951.

9. Spaet, T. H., Alway, R. H., and Ward, G.: Homozygous type "C" hemoglobin. Pediatrics 12:483, 1953.

10. Edington, G. M., and Lehmann, H.: Haemoglobin G. Lancet 2:173, 1954.

11. Zuelzer, W. W., and Kaplan, Eugene: Thalassemia-hemoglobin C disease: A new syndrome presumably due to the combination of the genes for thalassemia and hemoglobin C. Blood 9:1047, 1954.

12. Kaplan, E., Zuelzer, W. W., and Neel, J. V.: Further studies on hemoglobin C. II. The hematologic effects of hemoglobin C alone and in combination with sickle cell hemoglobin. Blood: 8:735, 1953.

13. Singer, Karl, Kraus, A. P., Singer, Lily, Rubinstein, H. M., and Goldberg, S. R.: Studies on abnormal hemoglobins. X. A new syndrome: Hemoglobin C-thalassemia disease. Blood 9:1032, 1954.

14. Sturgeon, Phillip, Itano, H. A., and Bergren, W. R.: Clinical manifestations of inherited abnormal hemoglobins. II. Interaction of hemoglobin E and thalassemia trait. Blood 10: 396, 1955.

15. Sturgeon, Phillip, Itano, H. A., and Bergren, W. R.: Clinical manifestations of inherited abnormal hemoglobins. I. The interaction of hemoglobin S with hemoglobin D. Blood 10:389, 1955.

16. Rigas, D. A., Koler, R. D., and Osgood, E. E.: New hemoglobin possessing a higher electrophoretic mobility than normal adult hemoglobin. Science 121:372, 1955.

17. Rucknagel, D. L., Page, E. B., and Jensen, W. N.: Hemoglobin I: An inherited hemoglobin anomaly. Blood 10:999, 1955.

PEDIATRIC ANESTHESIA*

F. Hays Threlkel, M.D.
Owensboro

PEDIATRIC ANESTHESIA[1] is already arising as a specialty within a comparatively new specialty. The progress made in anesthesia during this century is chiefly limited to the last 10 years. The average surgeon today has only recently begun to realize the importance of the anesthetic and the dangers involved. With a child patient, particularly, he expects the anesthesiologist to assume full responsibility for just about everything except the actual cutting procedure.

With this changing picture in the practice of surgery, the recent progress in anesthesia, and the growing responsibility of the anesthesiologist, a word of caution is indicated. Willis J. Potts, M.D.,[2] surgeon-in-chief, Children's Memorial Hospital, Chicago, as a part of his address at the dedication of Abbott's Exhibit, "The Conquest of Pain," March 15, 1955, at the Museum of Science and Industry, had the following to say:

> "Anesthesia has had a lot of labor pains and has only just brought forth this important robust child as an acceptable member of the medical profession. How this child grows and how it acts is the responsibility of the leading anesthesiologists of the country. You have a tremendous task before you in making this child not only acceptable but also essential and lovable. At present, he is a brat showing off and doing things he shouldn't do. Don't misunderstand me—I love this brat but I'm worried about him. I feel now like the bachelor giving advice about the care of children. Here the metaphor ends but not the free advice.
>
> "There has arisen a tendency to make anesthesia too complicated. It is a fact that anesthesiologists are still in competition with nurse anesthetists. The nurse with six months to a year of training is still giving lots of anesthetics and doing a creditable job. Consequently, the physician anesthesiologist feels that he must justify his four years in medical school, one year as an interne, and three years as a resident. He can justify this long period of training only by doing unusual things when for the routine standard operation a simple method is safer. It seems the physician hates to give a simple open mask ether anesthesia for a routine case. It's too easy. For children's surgery I believe nothing is safer. When a patient is premedicated with barbiturates, morphine and scopolamine, received pentothal in one arm, novocain in another, inhales a mixture of nitrous oxide and ether and then gets a snort of curare, that's when the trouble begins. An emergency arises and how can the anesthesiologist know what to do. I am convinced that simplicity and constant vigilance are the keynotes which you, the leaders, should sound with monotonous repetition.
>
> "We have heard much of cardiac arrest during surgery in recent years. That is a man made disease in the vast majority of cases. The solution to this problem lies in the hands of the anesthesiologist. Simplicity and constant vigilance in getting plenty of oxygen into the patient, getting the CO_2 out and giving the pain relieving agent with skillful restraint will, I am convinced, remove the spectre of cardiac arrest from the operating room. It is you, the leaders, who must preach from the housetops simplicity and constant vigilance. So much for the sermon —and I won't take back a word of it."

Dr. Potts' remarks are even more appropriate to pediatric anesthesia than to anesthesia in general.

Premedication and Preparation

The anesthesiologist insists on some form of premedication and usually in dosages larger than most pediatricians recommend. The belladonna group, particularly atropine, is a cause of wide disagreement. Each of you has seen the hot, dry, flushed, febrile child resulting from a large dose of atropine. It is not necessary to produce this picture in order to obtain the drying effect on secretions of the salivary glands and respiratory tract which is the reason for administering the drug.

Atropine is selected over scopolamine for children. The occasional mental confusion produced by scopolamine outweighs its sedative effect. This confusion may last for several hours into the postoperative period and can cause unnecessary apprehension for already worried parents.

Barbiturates are useful drugs and should be used routinely. Katherine Jackson, M.D.,[3] in a well controlled series proved that barbiturates

* *Presented at the 1955 KSMA Annual Meeting, Sept. 27-29 in Louisville.*

reduce tachycardia in anesthesia by 15 to 20%. Too, they lower the incidence of postoperative nausea and are a protection against convulsions.

Opiates produce a tranquilizing effect and may be used in all children over six months of age. If the child is in pain an opiate as part of the premedication is mandatory. Today with the drug Nalline to combat any depressing effects, opiates may be used with a wide margin of safety. No drug is superior to morphine, but Demerol is our choice purely because of the ease and accuracy in calculating the dosage. A prescribed 1/64 gr. of morphine may turn out to be anything from 1/128 gr. to 1/32 gr., whereas 10 mgms of Demerol will be as ordered. If the child is a "psychological vomiter" or subject to "car sickness" opiates are best omitted.

Premedication must be individualized. The robust, healthy child requires more than the asthenic, pale, sickly one. Dehydrated children do not need much atropine to prevent secretions.

The use of the above drugs is far more important in the pediatric patient than the so-called psychological preparation. Prior to surgery the anesthesiologist, time permitting, should see, evaluate, and gain the confidence of his patient. He should, however, within 20 seconds realize whether or not he is wasting his time in attempting to reassure a child who has been over protected by parents for years. All the anesthesiologist needs to do is to be honest and firm with the average child. The parents are the ones who need psychological preparation.

Induction

Any anesthetic agent powerful enough to produce rapid loss of consciousness is dangerous. Yet it is important to avoid frightening a child unnecessarily and to induce him rapidly. Chloroform and ethyl chloride are pleasant induction agents which were used extensively for children when we became interested in anesthesia 20 years ago. Today we use neither. Their direct depressing effect on the myocardium[4] plus the possibility of ventricular fibrillation early, more than outweigh any advantages they possess over safer drugs.

We prefer to induce children two years and older with divinyl ether (Vinethene). This agent has a wide margin of safety and acts rapidly. Its chief drawback is its tendency to stimulate secretions. For certain good-risk, terror-struck and excited children we use Sodium Pentothal rectally[5] to produce a basal narcosis while the patient is in his own room. We prefer this to Avertin because of the ease with which it is administered and, too, the smaller volume is not as likely to be expelled. We use 0.2 cc per lb. of body weight of a 10% solution. These patients will respond to painful stimuli and will react slightly when ether is started. Attention to detail is mandatory when Pentothal-ether is used. These children are depressed from the Pentothal and may become apneic with very little ether. For infants we feel that open drop ether is probably the safest agent from the start.

Another factor to be considered when discussing induction in private practice is time. The average surgeon is more than willing in bad-risk and selected cases to stand or sit "scrubbed" for an indefinite period of time while you "put the patient to sleep." If this happens too often, though, he becomes justifiably upset. It is nice to blow 80-20 nitrous oxide-oxygen over the child's face, or to play games and show him pretty objects before actually beginning the anesthetic, but to the busy surgeon these are unnecessary time consuming procedures.

Maintenance

The safest and least toxic maintenance agent in infants and children is diethyl ether given by the open drop technic. When Vinethene is used for induction, ether is started in conjunction with the Vinethene as soon as the child has lost consciousness. Unless this is done the youngster will have eliminated the Vinethene before there is a sufficient concentration of ether in the body to keep him asleep.

The depth of maintenance depends on the type of surgery being performed. Intra-abdominal surgery requires muscle relaxation whereas inguinal hernias may be repaired under much lighter anesthesia. Anesthesia should be no deeper than is necessary to permit the particular surgical procedure. The lighter the child is carried the fewer complications. The child, however, must be deep enough to be in light surgical anesthesia in order to be below the vomiting stage. The infant passes from one

stage to another more rapidly than the adult or older child. Here again the anesthetist must be alert for changes.

An adequate oxygen intake and carbon dioxide elimination is essential for proper maintenance. The infant normally breathes faster than the adult and if excess carbon dioxide is allowed to accumulate beneath the mask respirations are further stimulated and an exhaustive type of breathing results. Carbon dioxide excess must be reckoned with in every pediatric anesthetic. Dead space should be kept at a minimum by removing towels from around the mask and by a large flow of oxygen under the mask. This flow of oxygen at four to 10 liters per minute insures an adequate oxygen supply and washes carbon dioxide from the mask.

The dangers of hypoxia are greater and farther reaching than in the adult. Only time will tell the eventual result of hypoxia in a baby—a cerebral palsy, a personality disorder, a mental deficiency, a deaf mute. We can only surmise how many children are retarded in mental development by an anesthetic during which the child remained in a slight to moderate cyanotic state. Rapid respiration, slow pulse, pallor, muscle contractions, and cyanosis are danger signs of hypoxia. Every child receiving an anesthetic should have an excess oxygen supply.

Following surgery the infant or child should be placed on its side in slight Trendelenburg for gravity drainage of the pulmonary tract and to prevent aspiration of vomitus. This position should be used on the carrier from the operating room to the ward as well as in the patient's bed.

Other Methods and Agents

Since simplicity is our theme in pediatric anesthesia we have purposely omitted the use of the anesthetic gases. Gas machines for the infant and small child must differ from those designed for adults because of the physiological differences. The child's tidal volume is so much less that even the smallest mask and tubing increase the dead space and allow excess carbon dioxide accumulation even though a greater volume of gases is flowing.

If a gas machine is to be used, as is necessary in surgery involving the open chest, special attachments are required. For the "to and fro" absorption technique small soda-lime canisters and small re-breathing bags should be used. For the circle absorption method, the tubes must be shortened and the valves must work easily.

Pentothal intravenously is not recommended for children under six years for several reasons.[6] The respiratory depression in children is out of proportion to the suppression of reflexes. The amount of Pentothal required is out of proportion to the weight of the child. The size of the bronchial tree makes the bronchoconstrictor action of Pentothal more important in children. Then, too, difficulty in finding a suitable vein may be a problem.

Spinal anesthesia can be used safely in infants and children. Procaine is the safest drug in the dosage of one mgm per pound. Extreme muscle relaxation is produced but the child's intestine will remain distended in contrast to the ribbon-like contraction of the intestine of the adult. We have used spinal anesthesia in children under three years of age who had co-existing respiratory infections. Spinal anesthesia is also our choice for abdominal conditions in diabetic children and those with cardiac decompensation. These children must be well sedated or else the numbness of the lower extremities produces restlessness. We generally use pentobarbital sodium per rectum.

Curare which is such a boon in adult anesthesia has a more conservative place with infants. With ether it is not required nor indicated. With the gases it is helpful to produce muscle relaxation but for abdominal cases it must be given in dosages sufficient to produce apnea or else it adds to the exaggerated excursion of the diaphragm of infants.[7] Robert M. Smith, M.D., Chief of Anesthesia at the Boston Children's Hospital where Robert E. Gross, M.D., is chief of surgical services, states rather bluntly that in infants and children muscle relaxants "should never be used under any circumstance. Their use should be thoroughly condemned."[8]

Local anesthesia may be used successfully during the first three weeks of life since pain sensation is not well developed, although some is present. The operation for pyloric stenosis is frequently done under local anesthesia alone. The average older child, though, is too ap-

prehensive and too active to be a good subject for local anesthesia.

Intubation is necessary for pulmonary and cardiac surgery. It is also indicated in certain procedures about the face, nose, and mouth in which the pharynx is "packed off." In spite of Dr. Stephen's recommendation in his new book[9] that tonsillectomies be done under endotracheal anesthesia, we agree with the majority of nose and throat men that intubation is unnecessary and even dangerous.

We feel that endotracheal anesthesia should be reserved for open chest cases and those cases of head and neck surgery in which insufflation is inadequate. Actually, complications are not a major worry. Pender[10] in his analysis of 3,213 intubated children at the Mayo Clinic showed that there were fewer complications in children than in adults. Still it is better not to risk the possibility of trauma, edema, or infection unless there is a definite indication for intubation. We also personally feel that endotracheal anesthesia should be used only in emergencies during the polio season.

Regardless of the surgery involved the pediatric anesthesiologist must always be prepared to expose the glottis with a laryngoscope and pass a tube into the trachea. No other method of resuscitation compares with artificial respiration and administration of oxygen through the endotracheal tube.

Complications

Since anoxia or hypoxia is the greatest danger in anesthesia we must avoid as many respiratory complications as possible. A poor airway is the cause of most anesthetic complications. In the infant without teeth the tongue may be sucked up against the roof of the mouth and completely block mouth breathing. Too, enlarged tonsils and adenoids are encountered which obstruct respiration. Aspiration of vomitus may result in a generalized broncho-constriction with immediate death. Aspiration of a loose deciduous tooth is always a danger. The anesthetist should check for loose teeth as well as for foreign bodies. Quite frequently we find chewing gum in the child's mouth after he is on the operating table. Excessive secretions often are present after a stormy induction. An additional dose of atropine or scopolamine is beneficial.

Hyperpnea is a common complication. Too rapid a respiratory rate in an already sick child will produce exhaustion. Too often we see infants under ether with a respiratory rate in excess of 100 per minute. A gaseous acidosis caused by poor elimination of carbon dioxide plus an acidosis resulting from vomiting and starvation results in a hyperpnea that is dangerous to the child. Oxygen under the mask and molar lactate solution intravenously are therapeutic measures. A small dose of morphine intravenously is indicated if the above fail.

Circulatory disturbances are not common. Tachycardia is an accepted feature of the anesthetized infant and child—the pulse rate usually between 150 and 200 per minute. With the exception of active myocarditis, or decompensation, heart cases tolerate anesthetics well.

Loss of fluids resulting from diaphoresis due either to carbon dioxide excess or a hot operating room is always a possibility. Fluids should be started prior to surgery in every case of expected long duration. The tendency today, however, is to overhydrate the surgical child. Particularly is this true of the pediatric consultant who every day treats dehydration in the acutely ill child. Dr. Smith in his refresher course last fall in Cincinnati[11] had this to say: "The maintenance of fluid and electrolyte balance in pediatric anesthesia is of importance second only to that of adequate ventilation. The dangers entailed in fluid therapy in infants call for considerable exactness. Though rapid loss of body water may lead to dehydration and shock, overtreatment may quickly lead to pulmonary edema and death . . . The tendency should be to keep the patients relatively dry, since greater danger is associated with over hydration."

Summary

Pediatric anesthesia is becoming a specialty within a specialty. Manufacturers of anesthetic machines are designing equipment to meet the physiological differences between infants and adults. In general open drop inhalation technic with continuous oxygen supplied under the mask is the safest procedure to follow. The child should receive premedication to allay fear and diminish secretions. He should be carried only as deep as the surgery requires but must

be kept below the vomiting level. He should be left on his side in Trendelenburg position, even when being transported from the operating room to the ward, until awake. Body fluids must be conserved and fluid loss and electrolytes should be replaced. Again to quote Dr. Potts, pediatric anesthesia should be based upon "simplicity and constant vigilance."

References

1. Leigh, M. Digby and Belton, M. Kathleen: *Pediatric Anesthesia*, The Mac Millan Co., New York, 1948.
2. Potts, Willis J.: "The Conquest of Pain," given at the Dedication of the Exhibit at the Museum of Science and Industry, Chicago, March 15, 1955.
3. Jackson, Katherine: "Tachycardia in Children During Anesthesia," *Anesthesiology* 9:573-584 (Nov.) 1948.
4. Adriani, John: *The Pharmacology of Anesthetic Drugs*, Springfield, Illinois, Thomas, 1947.
5. Burnap, R. W., Gain, E. A. and Watts, E. H.,: "Basal Anesthesia in Children Using Sodium Pentothal by Rectum"; *Anesthesiology* 9:524-531 (Sept.) 1948.
6. Macon, Edward B.: "Clinical Anesthesia in Children", *Anesth. and Analg.* 25: 163-167 (July-August) 1946.
7. Smith, Scott M.: "The Use of Curare in Infants and Children", *Anesthesiology* 8: 176-180 (March) 1947.
8. Gross, Robert E.: *The Surgery of Infancy and Childhood*, W. B. Saunders Co., Philadelphia, 1953. (by permission of publishers)
9. Stephens, C. R.: *Elements of Pediatric Anesthesia*, The Charles C. Thomas Co., Springfield, Illinois, 1954.
10. Pender, John W.: "Endotracheal Anesthesia in Children: Advantages and Disadvantages", *Anesthesiology* 15: 495-505 (Sept.) 1954.
Adriana, John anu Griggs, Thomas S.: "An Improved Endotracheal Tube for Pediatric Use", *Anesthesiology* 15: 466-470 (Sept.) 1954.
Burnstein, Charles L.: "Pediatric Preanesthetic Preparation", *Anesthesiology* 14: 567-571 (Nov.) 1953.
11. Smith, Robert M.: "Water and Electrolyte Balance in Pediatric Anesthesia", Refresher Lecture Course, American Society of Anesthesiologists, Cincinnati (Oct.) 1954.

CANCER OF THE GENITOURINARY TRACT*

PETER L. SCARDINO, M.D.
Savannah, Georgia

AN INTELLIGENT APPROACH to the treatment of cancer of the genitourinary tract requires an appreciation of two essential factors—"a realistic appraisal of knowledge concerning neoplastic disease"[1] and a simplification of the art of detection. This second factor, detection, depends somewhat upon the first—knowledge of the disease. Our charge then is to present some of the aspects of neoplastic disease of the genitourinary tract and the simple techniques of detection involved in order that treatment may proceed intelligently.

Two important aspects of cancer of the genitourinary tract, if considered separately and then jointly, will enhance the physician's ability to cope better with this discouraging scourge. If one were to visualize the genitourinary tract as equally divided into two parts—(1) bloody urine and (2) prostatic cancer—the discussion could then revolve around these two segments of the problem.

If, for the sake of argument, one were to accept the statement that bloody urine is caused by tumor of the genitourinary tract, evidence to the contrary notwithstanding, until proved otherwise, then many hours of sleep would be added to the restless nights of the physician. Let us explore this entertaining and challenging idea.

Bloody Urine

The most common cause of bloody urine in the older male patient is benign prostatic hypertrophy. In the younger male and in all females, the common cause of this sign is urinary tract infection. However, medicine is not a numbers game nor a game of chance, and especially not in the department of urology. Thanks to our forebears the available tools permit us to make a specific diagnosis most of the time if only we have a chance to use these simple tools. While the chances are that the source of bleeding is the benign prostate or the infected bladder or perhaps urinary stones, it is a simple matter indeed to cystoscope the patient at the time of bleeding and determine the source of the abnormal sign.

The result of treatment of invasive carcinoma of the urinary bladder is a blight on the escutcheon of the urologist. Why is it so? The simple answer is that either the patient or the patient and his physician ignores the first sign of bloody urine whether it is microscopic or gross. Carcinoma of the bladder, if limited to the mucosa can be cured almost 100 percent of the time by almost any acceptable method of therapy. But once the neoplasm has invaded the muscle, the chances of cure diminish as rapidly and as precipitously as water over a steep falls regardless of the therapy involved.[2,3] All too often the therapy involved creates more problems than the original disease. Whether this therapy consists of total cystectomy and diversion of the urinary

* *Presented at the 1955 KSMA Annual Meeting, Sept. 27-29 in Louisville.*

stream[4] or other fancy surgical intervention;[5] radioactive cobalt[6] or phosphate or other forms of radiation therapy, the results of treatment of invasive carcinoma of the bladder are somewhat less than satisfactory. The answer to the problem is a straightforward challenge. Bloody urine requires a cystoscope as much as love does a kiss.

Upper Urinary Tract

And so it goes for the upper urinary tract, in regard to carcinoma of the ureter and renal pelvis.

Unless the ureteral or pelvic neoplasm is confined to the mucosa or submucosa as a papillary lesion it is notorious for its invasiveness.[7] The diagnosis can be made by a pyeloureterogram and is often suggested by the long clots which represent ureteral cast. Nephroureterectomy and removal of a cuff of bladder is the treatment of choice.

Most urologists who have been in practice less than 30 years have never seen a benign renal tumor. Therefore, one can unequivocally state that all kidney tumors are cancers. It is a joy to be proved incorrect in this business. Over two percent of all cancer deaths in the state of Kentucky are due to renal neoplasms. What makes these lesions so treacherous is their failure to produce symptoms until metastases have occurred. It is not uncommon to find small renal carcinomas at routine autopsy. But when the new growth has invaded blood vessels, blood will appear in the urine either microscopically or grossly. The urologic literature has recently been replete with reports of cases of unexplained hematuria. Authors and this one not excepted, have in glowing terms reported series of from six to 25 or more cases of unilateral renal bleeding in which no pathology was demonstrated either preoperatively or by the pathologist.[8] The reader would be led to believe that the guilty kidney should be left in situ and a wishful state of temporizing indulged in until the urologist can by one or another of his fancy tests prove the presence of pathology preoperatively. A false sense of security can be a dangerous pastime while this state of self-indulgence proceeds. Only recently this author has observed more than one such case which was followed for two years without demonstrable pathology until the inevitable nephrectomy revealed a large clear cell carcinoma in a young man. The removal of 20 so-called normal bleeding kidneys is not too great a price to pay for the removal of one small bleeding carcinoma in time.

Cancer of the Prostate

Perhaps more than 12 percent of cancer deaths in males in the state of Kentucky or about 350 men is due to cancer of the prostate.[9] What are some of the essential facts of this disease that might be of interest? First of all—cancer of the prostate is *not* a cause of bloody urine unless it has invaded the bladder and extended beyond any hope of cure with the tools available today. True enough, recent research has added to our toolbag corticotropin therapy,[10] radioactive gold,[11] and of all things, extirpation of the pituitary gland,[12] but the death rates have been little affected except by radical perineal or retropubic excision of the prostate and antiandrogenic therapy (estrogens and orchiectomy).[13,14] If bloody urine is one-half of the problem we visualized earlier, then cancer of the prostate is the other half.

Cancer of the prostate gland can be cured. But here again, the cooperation of the patient and his physician is the measure of just how many of these cases are even candidates for curative surgery.

If to establish the etiology of bloody urine is the first charge today, then annual rectal examinations on all males over 40 years of age is the second and perhaps even more important. The detection of one cm. of cement in the prostate gland on rectal digital examination should be a ticket to the operating room, perineal exposure, biopsy and radical prostatectomy. In no other manner can we reduce the death rate from carcinoma of the prostate. For while the benign gland will cause the urine to be bloody or obstruct its flow, and the median bar result in similar symptoms and prostatic calculi and infection cause frequency, urgency and dysuria, the early neoplastic gland will lie dormant in the bush like a wounded tiger until approached by the blade of the surgeon's scalpel. As many as 50 percent of the operable cases will be cured with an operative mortality less than that experienced

in the surgical treatment of the benign prostate gland.

Genital Tumors

Having considered the main actors, prostatic carcinoma and gross hematuria to have occupied the center of this imaginary stage, a brief consideration of the minor occupants in the wings is in order.

Testicular tumors are essentially of two main types— those that can be cured and those that cannot. But none can be cured if enlargement of the scrotal contents are observed to determine whether the suspicious mass changes in size over the course of a week or more. If the mass fails to transilluminate, is not cystic or is even questionable, simple orchiectomy is in order, not a biopsy, needle or otherwise. If the excised testis proves to be a seminoma, x-ray therapy is the treatment of choice and most patients will live long enough to succumb to something else.[15] If the pathologist reports embryonal or teratocarcinoma, a radical node dissection plus 3-500r to the pelvic and periaortic nodes up to the diaphragm will cure some of these people.[16] But chorioepithelioma and the mixed testicular tumors are in a classification by themselves. The most enthusiastic authors don't cure these people.

Cancer of the penis is a disease about which surgery can accomplish much. Simple amputation is strict surgical heresy. The lesion must be removed along with a sufficient amount of normal penile tissue to provide an area clear of tumor cells. And simultaneously a complete inguinal, iliac and femoral node dissection must be performed.[17] No other form of therapy is acceptable or gives encouraging cure rates.

Summary and Conclusions

There are other forms of new growths which the genitourinary tract is heir to, but those mentioned are the most common. Cancer of the bladder, ureter, renal pelvis and kidney are usually heralded in by the "blood-bath sign" and must be considered the causes of gross hematuria until proven otherwise. Cancer of the prostate, unlike benign prostatic hypertrophy and median bar, does not cause bloody urine during its curable stage. The curable stage is found only by doing digital rectal examinations annually on all male patients over 40 years of age.

Seminoma of the testis can be satisfactorily treated by simple orchiectomy and deep x-ray therapy. Other forms of testicular cancer will require radical orchiectomy with abdominal lymphnode dissection plus deep x-ray therapy. Likewise carcinoma of the penis requires excision of all the involved penile tissue as well as excision of the inguinal, femoral and iliac lymphnodes.

Bibliography

1. Leadbetter, W. F., Cancer of the Genitourinary Tract, N.E.J.M., 251: 519,562, 1954.
2. Jewett, H. J. and Strong, G. H., Infiltrating Carcinoma of Urinary Bladder. J. Urol. 55: 366, 1946.
3. Jewett, H. J., Carcinoma of Bladder; Treatment and Prognosis. South. M. J., 43: 661, 1950.
4. Whitmore, W. F. and Marshall, V. F., Carcinoma of Bladder. S. Clin. N. A., 33: 501, 1953.
5. Foley F. E. B., Richardson, E. J., Muluang, W. P. anu Victor, I., Massive Electrocoagulation of Vena cava for Prevention of Pulmonary Emboli. J. Urol. 70: 456, 1953.
6. Schulte, J. W. Hinman, F., Jr., and Low-Bur, B. V. A., Radiocobalt in Treatment of Bladder Tumors. J. Urol. 67: 916, 1952.
7. Foote, N. C., Humphreys, G. A. and Whitmore, W. F., Renal Tumors: Pathology and Prognosis in 295 Cases. J. Urol. 66: 190, 1951.
8. Finkle, A. L., Prince, C. L. and Scardino, P. L., Undiagnosed, Gross Renal Bleeding. J. Urol. 72: 111, 1954.
9. Cancer Facts and Figures, American Cancer Society, 1955.
10. Scardino, P. L., Prince, C. L. and McGoldrick, T. A., Bilateral Adrenalectomy for Prostatic Cancer. J. Urol. 70: 100, 1953.
11. Flocks, R. H. and Kerr, H. D., Radioactive Gold in the Treatment of Prostatic Cancer. J. Urol. 68: 510, 1952.
12. Scott, W. W., Year Book of Urology, Year Book Publishers, 1953. Pj. 514.
13. Jewett, H. J. Radical Perineal Prostatectomy for Cancer of Prostate, Analysis of 190 Cases. J. Urol. 61: 295, 1953.
14. Nesbit, R. M., and Baum, W. C. Endocrine Control of Prostatic Carcinoma. J.A.M.A., 143: 1317, 1950.
15. Lewis, L. G. Testis Tumors: Report on 250 Cases. J. Urol. 59: 763, 1948.
16. Cooper, J. F., Leadbetter, W. F. and Chute, R. Thoracoabdominal Approach for Retroperitoneal Gland Dissection: Its Application to Testis Tumors. Surg. Gynec. & Ost. 90: 486, 1950.
17. Hudson, P. B., Cason, J. F. and Scott, W. W. Analysis of 70 Cases of Penile Cancer Treated by Young Operation. South. M. J., 41: 761, 1948.

Manuscript Memos

Manuscripts should be submitted in duplicate to the Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month — day of month if weekly — and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The By-laws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The by-laws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.

THE INDUCTION OF LABOR WITH ITS INDICATIONS AND COMPLICATIONS THAT MAY ARISE FROM THE USE OF PITUITARY EXTRACT AND PITOCIN*

JULIAN B. COLE, M.D.
Henderson

EVERY DOCTOR who does obstetrics long will have the patient at or near term who will be benefited by the termination of her pregnancy. With this thought, I have chosen for a short dicussion with you this afternoon the induction of labor with the indications and complications from the use of Pitocin® and pituitary extract. If I may, I should like to give you a few statements concerning pituitary extract as a background for this discussion.

Pituitary Extract

The great enthusiasm for some agent that would initiate contractions of the pregnant uterus arose in 1909 when W. Blair-Bell used the extract of the posterior lobe of the pituitary to control post-partum hemorrhage. In 1911, J. Hofbauer, M.D., used pituitary extract to control uterine inertia.

Then, because of the tremendous enthusiasm for its use and because of the reported cases of uterine rupture, the problem seemed not to develop uses for pituitary extract in obstetrics but rather, ways of controlling its indiscriminate use in the hands of those who did not know its danger or did not rightfully care. Until approximately 1940, the use of pituitary extract to control uterine inertia was severely condemned and its use in the more recognized institutions was prohibited.

In 1927, Dr. Hofbauer, in an effort to minimize the danger of pituitary extract in controlling uterine inertia, presented the intranasal method of administration. It wasn't long, however, before accidents had occurred and this method was discarded as unpredictable and unsafe, and besides it was most unpleasant placing this wad of cotton soaked with pituitary extract under the inferior turbinates.

I might mention to you that in 1928, Oliver Kamm, M.D., and his associates at Parke-Davis laboratories separated the extract of the posterior pituitary into two fractions—one containing the oxytocic principle, "Pitocin" and one containing the diuretic and pressor principles, "Pitressin."®—and that in 1953, Vincent du Vigneaud, M.D., in the Department of Bio-chemistry at Cornell University Medical School, synthesized Pitocin, which is possibly the first time a polypeptide hormone has been synthesized.

About 1940, it became evident that the indiscriminate use of pituitary extract could not be stopped or controlled and a new emphasis was then begun on developing a safe procedure for its use. Consequently, such men as Dr. Theobold in England, Dr. Eastman at Johns Hopkins, and Dr. Dieckmann in Chicago began to test its use in full term pregnancies.

Determination of Dosage

It may seen elementary to you, but in normal labor the lower uterine segment is relatively inactive and the cervix is dilated from above downward. In using Pitocin for inertia, sometimes the dose is too large and this pattern will be reversed so that the midzone will do more work than the fundus with the result that no progress of labor is made and the fundal contractions are irregular and relaxation is poor. When there is a reversal of the normal uterine contractions, there is usually failure in the use of the drug with the resulting danger that the placenta may be squeezed and the baby be born anoxic.

In general, there is no correct or perfect dosage of Pitocin. There is no safe dose and no minims or milliliters or units. The threshold of uterine sensitivity may vary a hundred fold from one patient to another and the dose that would initiate the uterus to produce a noticeable contraction in one patient might rip the uterus wide open in another. We must remember that as term is reached the uterus becomes more sensitive to Pitocin with the peak being reached during labor. The intravenous use of Pitocin in uterine inertia and the induction of labor gives a higher percentage of success than when it is used intra-

* *Presented at the 1955 KSMA Annual Meeting, Sept. 27-29 in Louisville.*

muscularly and this may be explained on the basis of avoiding the cyclic overdosage and underdosage as when given by the intramuscular method.

Uses for Pitocin

The indications and uses for Pitocin in term pregnancies are many:

1. It may be used for the induction of labor when there are diseases which are specifically related to pregnancy, such as preeclampsia and eclampsia, placenta previa, premature separation of the placenta, polyhydramnios and we might mention premature rupture of the membranes without labor.

2. Induction may be done when there are diseases present such as tuberculosis, heart disease, nephritis, diabetes, hypertensive cardiovascular disease and other illnesses which might make early delivery advisable.

3. Induction should possibly be used in those cases that have had two or more stillbirths at term when the mother is in good health. Erythroblastosis may be mentioned. Of course, there would be a lot of argument on the subject of inducing the patient at about 30 weeks.

4. Induction is justified in cases of postmaturity. Of course, there has been much written concerning the dangers of post-maturity or prolonged pregnancy. Personally, I cannot recall a patient who has been definitely overdue. If everything points towards post-maturity, such as the time of the last menses and the size of the baby, the condition of the cervix will be the most helpful factor. If the cervix is becoming effaced and dilated, one may be sure that the patient is somewhere near term. In determining the size of the baby, don't be misled by the amount of amniotic fluid present or the possibility of twins.

In cases of toxemia of pregnancy, and I refer to preeclampsia and eclampsia, there are differences of opinion as to whether premature babies should be delivered by the vaginal route or by Cesarean section, but there may be a slight predominance in the concensus that the premature infant delivered by Cesarean section has less chance of surviving than those delivered by the vaginal route.

Some obstetricians, such as Dr. Eastman at Johns Hopkins and Dr. Dieckmann at the Chicago Lying-in Hospital take a much more conservative attitude towards the use of Pitocin and believe that its principal use before delivery is in labor when there is primary uterine inertia. According to Dr. Eastman, the labor must be true and not false and he stresses that the practice of pushing patients into labor may lead to accidents that will be difficult to justify. Before Pitocin is used in uterine inertia, therefore, one should question the advisability of not giving morphine and intravenous fluids, because so often after a sufficient rest, labor will progress rapidly.

Pitocin by the intravenous drip method has a definite place in controlling uterine atony and hemorrhage in the fourth stage of labor.

Technique of Induction

The technique of induction with intravenous Pitocin drip is simple. I use 10 minims of Pitocin in 1000 cubic centimeters of five percent dextrose in water and a 500 cc bottle of five percent dextrose in water connected by a Y tube or attached by a three way stop cock. A 22 gauge needle is placed in a vein in the forearm for ease of movement and fluid from the smaller bottle is begun. Then switch to the larger bottle with Pitocin. Do not insert the needle into the vein with the Pitocin flowing because a dangerous amount may be given before the amount of flow is regulated. The number of drops given per minute should be built up from zero, but not more than one fourth minim, 25 cc of the solution, should be given during the first half hour. Remember that the signs of overdosage occur most frequently during the first few minutes of administration. During the next half hour, give one half minim if the one fourth minim rate is not effective.

The quality of the contractions must be definitely ascertained by placing a hand on the abdomen and by questioning the patient. If the contractions last longer than two minutes, the solution should be cut off or if the fetal heart shows an abnormal beat, it should be discontinued. The contractions should be of good quality and no more often than two to three minutes apart and the uterus must relax between contractions. There should be a can of ether and other equipment on the side stand in case of tetanic contraction.

The physican should be present every minute that a patient is receiving intravenous

Pitocin for the induction of labor. If the doctor is to be away from the patient, the Pitocin may be discontinued and the solution from the smaller bottle begun again. Pitocinase is a plasma enzyme of pregnant women and is so concentrated that the Pitocin given intravenously is destroyed in approximately 90 seconds; therefore, in a period of two to three minutes after the intravenous is shut off, the effect has ceased. Incidentally, this ease of control is not shared with intramuscular Pitocin.

I give only 1000 cc of the solution in one day; however, if it is sufficiently important, often another trial the following day will be successful.

I have never ruptured the membranes to induce labor; nevertheless, it is one of the most effective ways of starting labor in the presence of Pitocin. It has been my unpleasant experience to have ruptured the membranes under other circumstances and the patient have a prolapsed cord which was not detected until the baby was asphyxiated.

The following are prerequisities for the use of Pitocin in inducing or stimulating labor:

1. The physician must be present at all times.

2. The patient must not be severely anemic, hemorrhaging severely or in shock.

3. The baby must be in good condition as determined by the heart sounds and by whether the amniotic fluid is meconium stained or not. A dead fetus is no contraindication, however.

4. The pelvis must be adequate.

5. There must be a definite and real reason for induction.

6. The patient must be in a hospital where she may get immediate treatment for any emergency which may arise.

7. If there is a doubt in your mind as to whether it should be used or not—don't. Remember that Pitocin is one of the most powerful drugs known.

Contraindications

The following are contraindications to the use of Pitocin:

1. There must be no obstruction or cephalopelvic disproportion.

2. A scar in the uterus from Cesarean section, etc.

3. Simply to speed up slow labor which is otherwise normal. If Pitocin is given a patient who is already having strong pains, the uterus may rupture, however small the dose may be.

4. It should not be given in the presence of shock.

5. Do not use Pitocin in breech presentations, especially frank breech.

6. It should not be used when the uterus is over distended as in twins or polyhydramnios.

7. There must be no mechanical obstruction.

8. It should not be used in women who have had four or more babies or are above 35 years of age.

I think that Dr. Dieckmann made an all-inclusive statement as to what he considered the primary indication for the induction of labor when he said, "The primary indication for the induction of labor must always be: Is the patient better off with her uterus empty, or if the infant is alive and in good condition, are its chances of survival increased by early delivery?"

If one uses Pitocin long enough, he will experience complications. These may be inadvertent, but the chances are greater that after he has done, say, 25 or more without getting into trouble, a certain confidence in the safety of the technique will arise and a certain relaxation towards the tremendous, treacherous powers will be acquired and it is at this time that the indications for its use will be broader and the contraindications gradually laid aside. It is at this point that we will see ruptured uteri, asphyxiated babies and premature babies. I know from experience that even after careful history taking and physical examination, induction of labor may be done at eight months instead of at term.

Conclusion

In conclusion, I should like to state that I believe the perfection of the procedure for the use of Pitocin in pregnancy at term parallels other great discoveries of medicine. If one is not constantly reminded that the most infinitesimally small dose may be hazardous, then there are going to be cases of catastrophic magnitude such as ruptured uteri, dead mothers, and dead babies.

A STUDY OF TUBERCULOSIS CAVITIES BY CONTRAST MEDIA AND OTHER METHODS*

Oren A. Beatty, M.D.

Louisville

WHEN A CAVITY IS OBSERVED to have a balloon-like appearance and contains a fluid level or fails to close with ordinary collapse procedures, it is often referred to as a tension or blocked cavity. The present study was done to give more information about cavities and their bronchial connections, the pressures within them, the location of the cavities, the physical signs overlying them, the auscultatory physical signs within, the direction of contraction of diseased lung tissue within which cavities are found and other incidental information.

Cases may be selected for cavitary study when the procedure is safe, is not technically difficult, and may render some beneficial knowledge. It is necessary that the overlying pleural space be obliterated by adhesions. The older chronic cavities may be studied safely. New cavities with acute surrounding disease should not be studied in this manner. The examinations should be done in the presence of antibiotic therapy.

Method of Study

The case selected has a chest examination, preferably done by two or more physicians. Particularly noted are physical signs characteristic of cavities. The patient is then fluoroscoped in different positions and the cavity localized. Stratigram studies may help to localize the cavity anteriorly or posteriorly. The patient is now placed on the table in a position depending upon the location of the cavity and prepared. After study of the chest x-ray, the interspace and the distance from the sternum or spine is selected for insertion of the needle. This is done under local anesthesia with sterile technique. A number 19 needle connected with the manometer of a pneumothorax apparatus is first used. If no free pleural space is found the needle is advanced into the cavity and the pressure is obtained. If the cavity is very small and difficult to find, intracavitary auscultation may be done through this needle as well as instillation of the iodized oil.

Ordinarily, the smaller needle is withdrawn and a size varying from number 17 to number 13 used. The pressure is again observed as well as intracavitary auscultation. Anywhere from two or three to 10 cc of iodized oil may be instilled, depending upon the indications. The patient is then turned on his back or opposite side and sent to x-ray for PA and lateral films. Subsequent films may be made as indicated.

Statistics

Following Roentgen examination, the cavities have been divided into three groups. The larger group shows definite and free bronchial connections. The smaller group shows obstruction, later emptying, indicating only partial obstruction; and the other group shows complete obstruction with no emptying of the cavity.

The cases studied showed a shift of the mediastinum to the side of the cavity in 28 cases. The remaining seven showed no shift or shift to the opposite side for other reasons. Thirty cases showed the diseased lung retracted posteriorly. This was not true in three anterior cavities, one non-tuberculous and one cavity in the pleural space. Thirty-one cases showed superior retraction of the disease as evidenced by the bronchial and lobular structures. No superior retraction was noted in two anterior cavities, one apical and one pleural cavity. Some form of retraction or contraction of the diseased tissue was noted in all cases. (See Table No. 1). In the greatest per cent of the cases this was posteriorly and superiorly toward the most fixed point or least mobile part

Table 1

Physical Changes

Type of Cavity	Open	Partially Blocked	Completely Blocked
TOTAL	29	2	4
Mediastinal shift	25		3
Posterior retraction	24	2	4
Superior retraction	25	2	4
Anterior retraction	3	0	0
No retraction	0	0	0
Bronchiectasis	19	0	0
T. B. sinuses	3	0	3

* *Presented at the 1955 KSMA Annual Meeting, Sept. 27-29 in Louisville.*

of the chest. Therefore, normal lung tissue and other mobile chest structures were drawn toward this point. Where there was limitation of the destruction of tissue to one lung, the opposite lung was retracted across the anterior mediastinum into the opposite chest. This was demonstrated by lateral x-ray which showed a very clear anterior mediastinal space. (See Figure No. 1). It was more dramatically demonstrated in one case not reported here, when a right traumatic pneumothorax was obtained in trying to enter a left upper lobe cavity, anteriorly, by going just lateral to the midclavicular line. Bronchiectasis was a very fre-



Figure No. 1. PA and left lateral films. PA film shows cavity filled by constrast media, bronchiectasis, elevation of left bronchus and diaphragm. Lateral film shows destroyed left lung contracted into posterior gutter. The clear anterior mediastinal area is due to right lung being pulled across anterior mediastinum.



Figure No. 2. PA and left lateral films. PA film shows a large infra-clavicular and a smaller apical cavity and bronchiectasis. The lateral film shows the position of the bronchiectasis relative to the cavity and that the interlobar septum is pulled anteriorly.

quent complication of cavitary destruction of lung tissue, appearing in 19 cases.

Because most cavities were posteriorly and superiorly located, the bronchiectasis was mostly anterior and inferior to the cavity. Bronchiectasis was not demonstrated in any of the partially or completely blocked cavities.



Figure No. 3. PA and left lateral films show completely blocked cavity in destroyed LUL and sinus tract in mediastinum near hilus. At resection, this oil was found extrapleurally. Following extrapleural resection, residual oil was seen extrapleurally in apex and mediastinum.

(See Figure No. 2). It was difficult to differentiate atelectasis and contraction due to destructive disease and fibrosis. It was further noted that of the four completely blocked cavities, three had apparently formed sinuses, intra- or extra-pleurally. There was questionable sinus formation in the other blocked cavity and three other cases. Sinus formation occurred eight times more frequently in the completely blocked cavities. (See Figure No. 3).

According to the x-rays and intra-cavitary pressures, there were 29 cavities with open bronchial connections, two with partially blocked connections and four completely blocked. In the open cavities the bronchial connections were either single or multiple. All 29 of the open cavities had atmospheric pressures. The two partially blocked had pressures ranging around zero to plus four, one completely blocked cavity had a high negative pressure, one an atmospheric pressure and the other two had pus within them preventing obtaining pressures. (See Table No. 2).

Table 2
Pressures in Cavities

Type of Cavity	Open	Partially Blocked	Completely Blocked
TOTAL	29	2	4
Atmospheric	29		1
Positive		2	
Negative			1

In examination of the chest, particular care was taken to note physical signs which may be found in the presence of cavities. Cavernous cough, amphoric breathing, post-tussive suction, moist coarse rales and whispered pectoriloquy are frequently heard over cavities, although not pathognomonic. In the partially and completely blocked cavities these cavitary signs were not heard. Also, breath sounds, whispered, and spoken voice sounds were diminished over large cavities or partially blocked cavities. Although this is too small a number of cases from which to draw conclusions, it does suggest that physical signs of cavities are rarely heard over partially or completely blocked cavities. (See Table No. 3).

In addition to the physical examination done previous to the cavity studies, one staff member suggested that auscultation be done directly through the needle into the cavities. This was done in many cases. It has been pointed out in the text books that the vesicular sounds origi-

Table 3
Physical Signs

Type of Cavity	Open	Partially Blocked	Completely Blocked
TOTAL	29	2	4
Cavernous cough	7		
Amphoric Bg	6	1	
Post tussive suction	2		
Moist coarse rales	9		
Whispered pectoriloquy	5		
Br. or Bv. Bg	25	1	1
Increased VR	22		1
MC rales ac	21	1	3
Distant Bg	5	1	1
Decreased VR	5	2	1
P. T. wheeze	6		1
Resp. wheeze	5	1	1

nate in the pulmonary parenchyma and the bronchial from the bronchial tree. If there is intervening consolidation or inflammation the bronchial sounds may be heard on the surface. Intra-thoracic auscultation seemed to bear this out.

In four cases in which the needle lumen was in the alveolus, the breath sounds were vesicular. In three cases auscultation was carried out in the pneumothorax space. This gave vesicular sounds probably coming from the pulmonary parenchyma. When intracavitary auscultation was done in 25 cases the sounds, when heard, were mostly of bronchial type. The breath sounds were mostly bronchial or bronchovesicular. Vocal resonance in general was increased. At times rales and also inspiratory and expiratory wheezes were heard. The above findings would indicate that these sounds were mostly of bronchial origin or that there was inflammation or consolidation near the bronchus or that the cavity wall was continuous with or adjacent to a bronchus. However, in 11 of these 25 cavities, no vesicular or bronchial sounds were heard. This cannot be definitely explained but various possible reasons may be offered. In two cases no sounds could be heard when auscultating through a number 19 needle but vesicular, bronchial sounds and rales could be heard when a number 15 needle was substituted. This suggests it may be possible to auscultate all cavities by increasing the needle size. This was further corroborated by an experiment. A rubber-capped glass jar containing two small openings was auscultated while a vibrating tuning fork was placed against the jar. In auscultating through the number 25 needle either no sounds or very faint sounds were heard. As the size of the needle was increased to 19, 18, 16 and 15, the sound of the tuning fork was increasingly heard. In auscultating inside the jar it made no difference in the sounds whether the second opening was closed or left open. It was noted that a vibrating tuning fork was best heard when the plane of the fork was perpendicular to the bevel of the lumen. Apparently the bevel acted somewhat as an ear. The location and position of the bevel and lumen relative to the bronchus or its orifice or the cavity wall may have been another reason why no sounds were heard in some cases.

Discussion

It would seem from observations that there is a natural tendency for diseased lung tissue to contract and heal. The cavity is an area of destroyed lung which has been expectorated and tends to follow the direction of the contraction of the surrounding diseased lung. In this small group of 35 cases not nearly so many blocked cavities were demonstrated as suspected. Eleven percent were completely blocked, six percent partially blocked and 83 percent showed a very free connection with the bronchial tree. This indicates that the cause of non-closure of cavities, in the majority of cases, is not due to their being blocked. If closure does not result, then some other mechanical difficulty may be present. Obstruction may cause nonclosure, but it is not as frequent as other causes. Pleural adhesions which prevent the natural relaxing type of contraction of lung tissue, or dense fibrous tissue in the vicinity of the cavity more frequently causes non-closure. Without mechanical difficulties it is felt that open and completely blocked cavities should close more readily than partially blocked cavities. However, in the completely blocked cavity unless the cavity can completely inspissate, close and heal with walls in eventual apposition, it is doubtful that this is desirable. Furthermore, this was borne out by the frequency of sinus tracts noted in the completely blocked cavities. There was evidence of these tracts extra-pleurally following surgery in three cases done. These may be potential hazards for the development of tuberculous complications following surgery. It cannot be completely explained at this time why no bronchiectasis was found in completely and partially blocked cavities, unless this blockage prevented the iodized oil entering the bronchiectatic areas. Also, it

(Continued on Page 431)


TRANS WORLD AIRLINES
FLY TWA



ACHROMYCIN®

Tetracycline *Lederle*

in the treatment of

respiratory infections

January and his associates[1] have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

No matter what your field or specialty, ACHROMYCIN can be of service to you. For your convenience and the patient's comfort, Lederle offers a *full* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.

dry-filled sealed capsules

For more rapid and complete absorption. Offered only by Lederle!

[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

Lederle

LEDERLE LABORATORIES DIVISION

AMERICAN CYANAMID COMPANY

PEARL RIVER, NEW YORK

®REG. U. S. PAT. OFF.

PHOTO DATA: 4X5 VIEW CAMERA, F5.6, 1/25 SEC., EXISTING LIGHTING AT DUSK, ROYAL PAN FILM.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1956 Annual Meeting — Kentucky State Medical Association

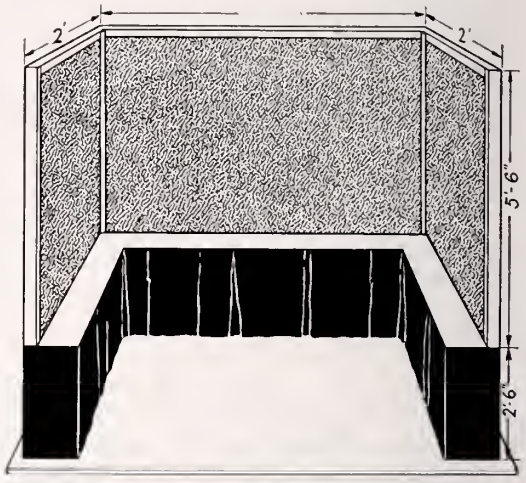
Columbia Auditorium — **Louisville, Kentucky** — **September 18, 19, 20**

Fill Out and Mail to:

EVERETT L. PIRKEY, M.D., Chairman
Committee on Scientific Exhibits
Louisville General Hospital,
Louisville 2, Kentucky

(Applications for space should be received before July 1, 1956)

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No. ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

may be possible that these bronchi which have such small openings connecting with the cavities have more resistance to the development of bronchiectasis. The resistance of the bronchus to bronchiectasis may play a role in the cause of tension cavities.

Apparently obstruction of bronchi definitely influences physical signs. No cavitary signs were heard over partially and completely blocked cavities.

Intrathoracic and intracavitary auscultation has not been done enough to evaluate. We feel that intracavitary auscultation of cavities and lungs should be pursued further before definite clinical value may be demonstrated. It does seem to demonstrate that vesicular sounds come from the pulmonary parenchyma and that the other sounds come from the bronchial tree. This would tend to explain why no amphoric breathing, post-tussive suction and other cavitary signs were heard over cavities where a blocked bronchus is present, or over very large cavities.

Summary and Conclusions

1. Thirty-five cavitary cases in which iodized oil has been instilled have been studied.

2. Twenty-nine cavities had free bronchial connections as evidenced by atmospheric pressures and x-ray findings. Two cavities were partially blocked as evidenced by positive pressures and x-ray findings, and four cavities were completely blocked as shown by x-ray. One of these had a negative pressure, one atmospheric and the others contained fluid.

3. The ordinary physical signs suggestive of cavity, such as amphoric breathing, cavernous cough and post tussive suction, were not heard over any of partially or completely blocked cavities. In intrathoracic and intracavitary auscultation it appears that the vesicular sounds come from the alveoli and the other sounds from the bronchi.

4. Diseased tuberculous tissue with which cavities are frequently associated tend to contract and move toward a fixed point posteriorly and superiorly. Normal lung tissue follows this contraction and it may be pulled across the anterior mediastinum. Normal lobes move in the direction of the contraction.

5. Extensive pleural adhesions and dense fibrous tissues surrounding cavities prevent the contracting relaxation of lung tissue in the closure of cavities more frequently than a partially blocked cavity. Obstruction is not the most frequent cause of non-closure of cavities.

6. Sinuses extending out from the cavities into the extrapleural spaces were noted in the completely blocked cavities and not in the other two types. Tuberculous sinuses occur eight times more frequently in the completely blocked cavities.

7. Bronchiectasis is frequently seen in association with open cavities and was not seen in any partially and completely blocked cavities.

ANTICOAGULANTS IN MYOCARDIAL INFARCTIONS

Stuart Graves, Jr., M.D.
Louisville

THERE IS A GREAT DIFFERENCE of opinion in the medical literature regarding the use of anticoagulants in the treatment of myocardial infarctions. I should like to review some of the factors involved in making the decision for or against anticoagulant drugs in the case of any particular patient.

"Routine" Use

The answer to this problem, as in many other problems in medicine, was sought in the analysis of statistics obtained from the treatment of a large group of patients with myocardial infarction as compared with a suitable control group. The American Heart Association appointed a committee to evaluate the effects of anticoagulants; and the committee's opinion was that all patients should receive anticoagulants unless a definite contraindication was present[1]. Wright, in reviewing this work[2], pointed out the following

Chart 1

Anticoagulants in Myocardial Infarctions

1031 Cases	Without Anti-coagulants	With Anti-coagulants
Deaths in entire series	23%	15%
Deaths in mild and moderate cases	12.9%	7.9%
Deaths in severe cases	45%	35%
Thromboembolic complications	45%	13%

From Wright

statistics based on 1031 cases. Deaths in the patients not getting anticoagulants were 23 per 100 as against 15 per 100 in the group getting anticoagulants. These 1031 cases were further divided according to criteria set up prior to the study; the mild and moderate cases on one hand, and the severe cases on the other. Deaths in the mild and moderate cases were 12.9 per 100 without anticoagulant treatment, and 7.9 per 100 in the treated group. In the severe cases there were 45 deaths per 100 without anticoagulants, and 35 per 100 with anticoagulants. Thromboembolic complications occurred in 45 per 100 cases in the group not given anticoagulants and 13 per 100 in those given anticoagulants. This would seem to be a high incidence of thromboembolic complications, but it must be noted that an intensive search was made for these complications, utilizing serial urinalyses, blood counts, chest films, electrocardiograms, etc. On the other hand, one cannot help feeling that the Committee reported, as thromboembolic complications, minor episodes that have little if any clinical significance. Be that as it may, the Committee found that 16 percent of the cases had one complication, five percent had two, three percent had three and one percent had four. They also observed that the highest incidence of complications occurred during the second week, 14 per 100 cases; and declined to less than three per 100 after the fourth week. As would be expected, a higher incidence of thromboembolic complications occurred in the poor risk patients. During the first three days of anticoagulant therapy there were seven complications per 1000 treatment days against 16 per 1000 days in a corresponding group that did not get anticoagulants. This is a little difficult to explain, since Dicumarol was used almost exclusively in this study, and one would not expect much benefit during the first 72 hours. From the fourth day after starting anticoagulants until the fourth day after stopping, there were three complications per 1000 treatment days against 12 per 1000 treatment days in the control group. Wright concluded from the above data and from autopsy findings the following: (1) anticoagulants have no effect on the coronary occlusion itself; (2) the lowering of the death rate is almost entirely due to the beneficial effect of anticoagulants in the group of patients with thromboembolic complications; and (3) anticoagulants should be used in all cases of myocardial infarction in which no contraindications exist.

"Selective" Use

An increasing number of physicians question the advice of Wright and others, at least in part. They feel that the favorable results obtained with anticoagulants are due to the benefit given the "severe cases." While very few physicians will withhold anticoagulants in the severe or complicated myocardial infarction, they feel that any benefit given to the "good risk" patient is outweighed by the hazards inherent in the use of these drugs. Russek and Zolman[3] support this view with the results obtained from the records of 1,047 consecutive admissions for acute myocardial

Chart 2

Anticoagulants in Myocardial Infarctions

1047 Cases	Without Anti-coagulants	With Anti-coagulants
Deaths in "good risk" patients	3.1%	0.7%
Thromboembolic complications	0.8%	1.1%
Deaths due to anticoagulants from two series of The Committee on Anticoagulants of The American Heart Association		

From Russek and Zolman

infarctions. The death rate of "good risk" patients selected from this group was 3.1 percent and the incidence of thromboembolism was 0.8 percent. A "good risk" patient as

defined by Russek and Zolman was one who had none of the following on the day of admission: (1) previous myocardial infarction; (2) intractable pain; (3) extreme degree or persistence of shock; (4) significant enlargement of the heart; (5) gallop rhythm; (6) congestive heart failure; (7) auricular fibrillation or flutter, ventricular tachycardia, or intraventricular block; and (8) diabetic acidosis or other states pre-disposing to thrombosis. Patients who qualified as "good risks" made up 46 percent of the total group admitted to the hospitals for myocardial infarction. Since the incidence of thromboembolic complications was only 0.8 percent, the maximum percentage of deaths due to thromboembolic complications that could possibly be prevented with anticoagulants would be 0.8 percent. The Committee on anticoagulants of The American Heart Association found in two different series, that the deaths due to anticoagulant drugs were 0.7 and 1.1 percent of the patients treated, respectively. Futhermore, these deaths occurred in leading medical centers equipped with the most reliable laboratories. The conclusion of Russek and Zolman is that "anticoagulant treatment is neither necessary nor desirable for a large segment of patients who sustain their first attack of acute myocardial infarction and present no unfavorable criteria for recovery at the time of the first examination."

It would seem from the analysis of the two schools of thought outlined above, that the policy of "selective" use of anticoagulants is a sounder policy than the "routine" use of the drugs in all cases of myocardial infarction.

Control of Therapy

Assuming that anticoagulant drugs should be used in severe or complicated myocardial infarction, there is still an extremely important factor to consider in the case of any particular patient; specifically, can the anticoagulation be controlled safely and yet have adequate levels produced. As stated earlier, the use of anticoagulant drugs in therapeutic dosage is not an innocuous procedure. The Committee on Anticoagulants of the American Heart Association observed mild bleeding, such as microscopic hematuria, five times per 1000 treatment days, and severe bleeding 0.5 times per 1000 treatment days. Death occurred in only a fraction of one percent, but it does occur in the hands of experts supported by the most reliable laboratories. The Committee on Anticoagulants also noted that anticoagulant therapy was twice as effective if the percentage of prothrombin activity was maintained at 25 percent of normal or less. The accepted goal in anticoagulation is to keep the percentage of prothrombin activity between 15 and 25 percent[4].

There is no apparent advantage of one anticoagulant drug over another. Dicumarol has certainly enjoyed the widest acceptance in America, although Hedulin® and Tromexan® have been used extensively. These latter drugs have a theoretical advantage in that they are somewhat shorter acting and more rapidly eliminated, thereby lessening the danger period in the event of overdosage. However, with adequate Vitamin K treatment in such cases, this advantage does not have any practical significance.

If, to use anticoagulants adequately means keeping the percentage prothrombin activity between 15 and 25 percent, one immediately realizes that danger is lurking fairly close by. What steps should be taken to insure the safety of the patient? First, one must have a dependable laboratory that can do accurate prothrombin times daily. There are many methods of doing prothrombin determinations, and all are satisfactory providing that they are reproducable within a very small limit of error. It has been found that a method using a constant temperature water bath is the most satisfactory. As yet, there has not been found a way to overcome the errors due to changes in temperature with which one is confronted in the bedside tests.

Factors Influencing Control

Several factors influence the patients response to Dicumarol and allied drugs. Probably the most common one seen in patients with myocardial infarction is renal insufficiency. This will enhance and prolong the response to Dicumarol and for this reason all patients should have some test of renal function prior to or during the first day or two of anticoagulation. Patients with liver disease are more sensitive to anticoagulants because they may have a deficient amount of prothrombin before treatment is started. Cachectic

or fasting individuals are also more sensitive to the drugs. It is amazing how rapidly this effect can be noted. The mere fact that a patient has been too ill to eat during the first five to six days of his infarction will often be enough to alter materially the effect of anticoagulants on the prothrombin time. These conditions are not contraindications to anticoagulant treatment, but they should be noted and the dosage schedule adjusted accordingly.

Many blood dyscrasias, severe ulcerative diseases of the gastrointestinal tract, bacterial endocarditis, and recent brain or spinal cord surgery are all contraindications to the use of the anticoagulant drugs, but they are rarely seen in cases of acute myocardial infarction.

Another contraindication, in a sense, is pericarditis. Actually, this is a problem of correct diagnosis. It can be extremely difficult to distinguish between myocardial infarction and pericarditis during the early hours of either condition. Because pericarditis is much more likely to be confused with a mild rather than a severe myocardial infarction, I believe this to be another reason why one should not routinely use anticoagulant drugs.

In the event of serious hemorrhage, cessation of the anticoagulant and the administration of vitamin K is usually sufficient. However, if the bleeding is massive, whole blood should be used in whatever amounts are necessary. The original experiences with water soluble vitamin K in the treatment of hypoprothrombinemia were disappointing. With larger and repeated injections of water soluble vitamin K or the use of the newer vitamin K_1 and vitamin K_1 oxide the results are quite satisfactory. The preferred treatment of hypoprothrombinemia is 50 to 150 mgms. of vitamin K_1 intravenously. It should be remembered that if large doses of vitamin K_1 are used, it will be impossible to use the anticoagulant satisfactorily again for a period of four to five days.

Heparin

The use of heparin should be mentioned in this discussion. Early in the history of anticoagulant treatment of myocardial infarction, heparin was used widely. Because Dicumarol requires 48 to 72 hours to obtain a therapeutic level, it was originally felt that heparin should be used to prolong the clotting time during this latent period. Because very few thromboembolic complications are seen during the first three days of a myocardial infarction, and because it is known that anticoagulants have no effect on the coronary occlusion or the myocardial infarction itself, heparin is no longer routinely used by most physicians. If the patient is first seen late in the course of the infarction, and if thromboembolic complications are already present, heparin should be used until the prothrombin time is prolonged to a therapeutic level.

Prolonged Use

I would like to mention one other use of anticoagulants that is closely allied to the subject under discussion, and that is the prolonged use of the drugs in cases of repeated myocardial infarction and even in persistent angina. If one looks upon myocardial infarction as one manifestation of thrombotic disease secondary to atherosclerosis, then there are very good pharmacological reasons why such cases should be carried on a prolonged anticoagulant regime. There are several groups in the country working on this program[5] but a definite answer can be given only after a period of many years of observation.

Summary

The results obtained in the treatment of two large series of myocardial infarction have been presented. It is the author's opinion that the "selective" treatment policy, as outlined by Russek and Zolman is the more sensible one, because any benefit given the "mild" cases is outweighed by the dangers inherent in the use of anticoagulant drugs.

The more common pitfalls encountered in the use of anticoagulant drugs have been mentioned, and steps have been outlined to minimize these dangers.

Bibliography

(1) Wright, I. S.; Marple, C. D., and Beek, D. F.; Report of the Committee for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infarction; Am. Heart J. 36: 801 (Dec.) 1948.

(2) Cornell Conferences on Therapy: Vol. IV, New York, The MacMillan Co. 1953.

(3) Russek, H. I.; and Zolman, B. L.; "Selective" versus "Routine" Use of Anticoagulants in Acute Myocardial Infarctions; J.A.M.A. 156 (Nov.) 1954.

(4) Goodman, L.; Gilman, A.: The Pharmacological Basis of Therapeutics. 2nd Ed. New York, The MacMillan Company, 1955.

(5) Scott, T.; Personal Communication.

CASE DISCUSSIONS

FROM THE UNIVERSITY OF LOUISVILLE HOSPITALS LOUISVILLE CHILDREN'S HOSPITAL

METHEMOGLOBINEMIA*

History

A two month old white female infant was admitted to the Children's Hospital on August 29, 1955 with the chief complaint of having turned blue on the day of admission. The patient was apparently well one day prior to admission and had slept all night. On awakening on the morning of admission she was found to be "blue all over," quite irritable and restless. The parents reported no respiratory difficulty. The family physician referred the patient to this hospital.

The patient was the product of a full term normal pregnancy and delivered from a cephalic presentation by low forceps. The birth weight was five pounds, five ounces. She had done well until one month prior to admission when she developed frequent loose stools daily. This persisted but the patient had gained weight steadily. During the two weeks before admission she had received approximately six teaspoonsful of "red medicine" for diarrhea. The only other known medication had been one teaspoonful of castor oil on two occasions the week before arrival at this hospital.

The patient was taking an evaporated milk formula, ordinarily prepared with cistern water. Due to mechanical difficulty with the cistern pump, four bottles of formula had been prepared with water from a "mineral" well. This particular formula was used two days before admission; that being the only occasion on which the child had ingested well water. There was no history of any previous respiratory difficulty or cyanosis. The patient and her family live on a farm in Washington County, Kentucky. No other member of the family had cyanosis.

*Hospital Protocol No. 37409

Physical Examination

Admission examination revealed on afebrile, well developed, well nourished, eight pounds, one and one half ounces, infant with marked cyanosis of the entire body. The respiratory rate was 80 per minute. The lung fields were clear to percussion and auscultation. There was no evidence of pneumonia, atelectasis, or pneumothorax. The cardiac rate was 140 per minute, the heart sounds were of good quality and no murmur was noted. The remainder of the physical was not remarkable.

Diagnosis

The occurrence of cyanosis without demonstrable ventilatory distress suggested methemoglobinemia. There is a known correlation between cyanosis and ingested well water of a high nitrate content.

The significant laboratory finding on admission was a methemoglobin determination of 3.2 gm. per cent (normal—less than 0.5 mgm. per cent). Subsequent analysis of the "mineral" well water demonstrated an increased nitrate content. The cistern water contained no nitrate.

Differential Diagnosis

J. A. Little, M.D.: Cyanosis may be caused by an increased amount of reduced hemoglobin in the blood at the site inspected. Localized cyanosis may be observed when cold or shock results in slowing of the circulation causing a local accumulation of methemoglobin. Generalized cyanosis occurs with pulmonary or cardiac disease. The intense degrees of cyanosis are more often due to abnormal pigments (methemoglobin and sulfhemoglobin) within the red blood cell. Clinical cyanosis can be observed with a blood level of 5 gm. per cent reduced hemoglobin, 1.5 gm. per cent of methemoglobin

or less than 0.5 gm. per cent of sulfhemoglobin. Some forms of congenital heart disease may present a clinical picture compatible with this history. In this case the absence of a cardiac murmur or signs of congestive heart failure lessened this possibility. The dramatic response to the intravenous injection of methylene blue established the diagnosis of methemoglobinemia. Methylene blue is of both diagnostic and therapeutic value.

Various therapeutic agents such as bismuth subnitrate can result in methemoglobinemia. The use of an unknown medicine for diarrhea presents such a possibility.

Management

The use of intra nasal oxygen failed to relieve the cyanosis. After blood was drawn for methemoglobin determination, six mgm. of methylene blue and 100 mgm. of ascorbic acid were given intravenously. Within two minutes the cyanosis was totally relieved. Analysis of the non-cyanotic blood revealed no methemoglobin. The baby took the evaporated milk formula well, remained acyanotic, and gained four ounces during the four days of hospitalization.

Discussion

QUESTION: What are some of the more common poisons causing methemoglobinemia?

A. J. Steigman, M.D.: Nitrites, nitrates, aniline derivatives, acetanilid, pyridium, dinitrophenol, and potassium chlorate. These agents may be ingested, injected, inhaled, or absorbed from the skin. If the toxic agent is withdrawn, spontaneous removal of the methemoglobin occurs.

QUESTION: What is the method of determination of methemoglobin?

Doctor Steigman: Quantitative estimation of methemoglobin can be done by use of the photoelectric colorimeter. Qualitatively the detection is by visual spectroscope of a dark band at 630 millimicrons. This band can be made to disappear by the addition of cyanide solution.

QUESTION: Why were no other members of the family adversely affected by the "mineral" water?

Doctor Steigman: Susceptibility to this disease rapidly decreases after the first two months of life and is rare after six months of age. The infant possesses much less total oxidizable hemoglobin than the adult and this is an important factor in making the infant more susceptible. In 1945 Comly* reported methemoglobinemia in infants due to ingestion of well water with a high nitrate content. He suggested that the following factors may play a role:

1. The bacterial flora of the infant intestine may include more nitrate converters than the adult's.
2. Gastro-intestinal upsets and mucosal injury may be more common in infants than adults.
3. In infants the high fluid turnover and rapid circulation may favor more complete absorption of the nitrate ion from the intestine.

QUESTION: Does boiling of water containing nitrates in large amounts affect the nitrate content?

Doctor Steigman: Comly* reported a case in which the unboiled well water was analyzed and found to have nitrate value of 140 parts per million, which is equivalent to 0.619 grams of nitrate ion per liter. Later a second sample was boiled the same length of time as that given to the baby. The boiled sample contained 0.530 grams of nitrate ion per liter and thus did not vary appreciably from the unboiled. One gram of potassium nitrate (salt peter) in a liter of water approximates this nitrate ion concentration.

QUESTION: What is methemoglobinemia?

Doctor Steigman: It is the presence of an appreciable amount of methemoglobin in the blood. Methemoglobin is a stable pigment in which the iron is in the ferric state. One molecule of nitrite ion reacts with two molecules of hemoglobin to form methemoglobin.

QUESTION: How does methylene blue correct methemoglobinemia? What is the dosage?

Doctor Steigman: By studying the molecular ratio of the hemoblogin produced per unit of methylene blue added, investigators are unable to explain the reaction on the basis of reducing action of methylene blue. Thus it was concluded the methylene blue is a catalyst which accelerates the rate at which the enzyme system of the red cell normally reverts methemoglobin to hemoglobin. An intravenous dosage of one to two mgm. of methylene blue per kilogram of body weight is effective, and no untoward re-

(Continued on Page 455)

*Comly, Hunter H.: Cyanosis in Infants Caused by Nitrates in Well Water, J.A.M.A. 129: 112-116, Sept. 8, 1945.

SPECIAL ARTICLES

THE END OF AN ERA

BARBARA N. MORGAN

". . . . the old years die and the new begin . . . ."
The Lost Shipmate
Theodore Goodridge Roberts

The Kentucky State Medical Association has had a Journal for 53 years. For 50 of these years this Journal has been published by the Times Journal Publishing Company of Bowling Green. This issue begins a "new publisher" era for the Journal. After half a century of faithful service the old publishers have decided to step out of the Journal picture and make way for a new publisher.



J. G. Denhardt

April 1956 marked the end of a business association that has for a long time, been much more than that.

The story of the KSMA Journal is, almost in its entirety, the story of J. G. Denhardt of Bowling Green, who owns the Times Journal Publishing Company.

It began several years before 1906 when Mr. Denhardt, a young man, began working in a drug store from 6 a.m till 11 p.m. through the week days and all day on Sunday except "for time out for Sunday School and church."

On a fateful July 4, the store burned and Mr. Denhardt, without a job went to work for the McCormack family of Bowling Green collecting bills for their store. This McCormack family later was to become prominent in the KSMA.

In 1882 the Denhardt family began publishing a daily paper in Bowling Green. Mr. Denhardt was by this time a good friend of the McCormacks, especially Arthur T. McCormack, who in 1906 became secretary of the KSMA. (A picture of Dr. McCormack still hangs in the office of the Times Journal.)

In 1903 the KSMA monthly Bulletin was started. In June 1904 at the suggestion of Steele Bailey, M.D., the name was changed to Kentucky Medical Journal. J. G. Denhardt and his brother William J. Denhardt, through the McCormack friendship, became the Journal publishers in 1906.

The newspaper building was a large four story building on the corner of Tenth and State Streets. Next door was a livery stable. In this building from 1906 to 1911 the Journal of the Kentucky State Medical Association was published along with the Bowling Green daily paper.

In 1911, Mr. Denhardt believes it was again July 4, the building burned to the ground and with it went all the machinery and "just about everything."

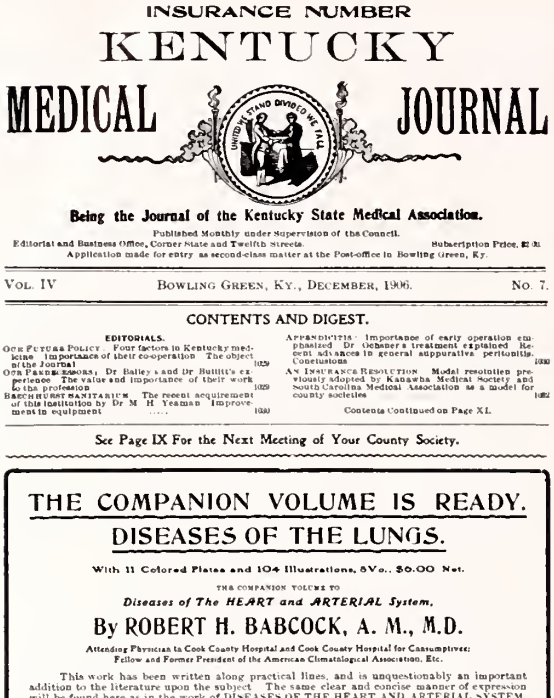
Again the McCormacks came to the rescue. They loaned the Denhardts money to buy new presses and equipment and the office was moved to its present day location on Tenth Street.

The new building, erected around 1876, had been a Christian Church. Today the building houses the publishing company downstairs and Betty's Beauty Bar, upstairs.

Mr. Denhardt recalls that around 1909 the physicians in Jefferson County decided they weren't getting enough play in the KSMA Journal so the "Jefferson County Number" a monthly publication between issues of the regular Journal was begun. (The Journal was then a semi-monthy publication. In 1915 the Journal again became a monthly.)

The physicians decided that the number would consist not only of articles from Jefferson County physicians but should carry only advertising from Jefferson County. Mr. Den-

hardt was elected to come to Louisville to help set up plans to sell the advertising. "I ended up by selling a great deal of it myself, but the doctors were nice to me, they didn't let me walk all over Louisville, but took me in their cars."



INSURANCE NUMBER

KENTUCKY MEDICAL JOURNAL

Being the Journal of the Kentucky State Medical Association.

Published Monthly under Supervision of the Council.

Editorial and Business Office, Corner State and Twelfth Streets. Subscription Price, $2.00

Application made for entry as second-class matter at the Post-office in Bowling Green, Ky.

VOL. IV BOWLING GREEN, KY., DECEMBER, 1906. NO. 7.

CONTENTS AND DIGEST.

EDITORIALS.

OUR FUTURE POLICY. Four factors in Kentucky medicine. Importance of their co-operation. The object of the Journal 1029

OUR PAGES. Books; Dr Bailey's and Dr Bullitt's experience. The value and importance of their work to the profession 1029

BASCH HURST SANITARIUM. The recent acquirement of this institution by Dr M H Yeamans. Improvement in equipment 1030

APPENDICITIS. Importance of early operation emphasized. Dr Gebauer's treatment explained. Recent advances in general suppurative peritonitis. Conclusions 1030

AN INSURANCE RESOLUTION. Model resolution previously adopted by Kanawha Medical Society and South Carolina Medical Association as a model for county societies 1032

Contents Continued on Page XI.

See Page IX For the Next Meeting of Your County Society.

THE COMPANION VOLUME IS READY.

DISEASES OF THE LUNGS.

With 11 Colored Plates and 104 Illustrations, 8Vo., $6.00 Net.

THE COMPANION VOLUME TO

Diseases of The HEART and ARTERIAL System.

By ROBERT H. BABCOCK, A. M., M.D.

Attending Physician to Cook County Hospital and Cook County Hospital for Consumptives; Fellow and Former President of the American Climatological Association, Etc.

This work has been written along practical lines, and is unquestionably an important addition to the literature upon the subject. The same clear and concise manner of expression will be found here as in the work of DISEASES OF THE HEART AND ARTERIAL SYSTEM.

The chapters devoted to Pneumonia and Tuberculosis will be found of especial interest at this time when treatment of DISEASES OF THE LUNGS is attracting international discussion.

Diagnosis and Treatment have received the consideration which their importance requires from the viewpoint of the general practitioner, and the work should prove a ready guide to the reader

Send for our New Illustrated Medical Catalog.

D. APPLETON & COMPANY, PUBLISHERS,

436 Fifth Avenue, New York City.

This was the KSMA Journal a half century ago. J. G. Denhardt became publisher in December 1906 and this was his first Journal. Arthur T. McCormack, M. D., Mr. Denhardt's close friend, was editor.

The Jefferson County number ran from April 15, 1909 to January 15, 1915 and "I made enough money selling advertising to go on a wedding trip." In 1912 Mr. Denhardt married a young Nashville girl named Eleanor. They have two children—a daughter in New Jersey and a son, who is the assistant to the mayor of Bowling Green. Mr. and Mrs. Denhardt are the boastful grandparents of eight grandchildren. "Jimmy", Mr. Denhardt, "is the best canasta player you've ever seen." Canasta is a hobby of Mr. Denhardt's.

About 20 years ago, after the children were grown, Mrs. Denhardt joined her husband in the publishing business. According to Mr. Denhardt, she has done all the make-up of the Journal pages and all the proof reading. "To her is due the major credit for whatever success we have achieved as publishers of the Journal", Mr. Denhardt said.

Not long ago a Bowling Green neighbor asked Mrs. Denhardt how she and Mr. Denhardt managed to set "all that type" themselves. She had to grin and admit quite honestly that neither she nor Mr. Denhardt has ever or could ever set a line of type.

A crisis hit the Denhardts during World War II. "We made it very well through World War I and even though we had a pretty tough time during the depression we got through all right." When World War II came, however, it was a different story. "Every time we got a new printer, the drafft board called him." Finally it was necessary to stop the publication of the Times Journal daily paper. Since World War II the KSMA Journal has been the only "big" publication for the Denhardts, and they have taken an untold amount of interest in it. Of course, they have done printing jobs on the side and will continue to do so.

When talking about World War II, Mr. Denhardt says "They woudn't take me in the army so I went out and sold war bonds. I sold



The KSMA Journal has been published in this building since 1911. The building, erected in 1876, was a Christian Church. It is located on 10th Street in Bowling Green.

over a half million dollars worth and the funny thing is I didn't buy a one myself."

Mr. Denhardt who proudly boasts that he has missed but a few of the KSMA Annual Meetings in all these 50 years, was born in Bowling Green and has lived there all his life. He'll laughingly tell you he "helped lay out the town." He is or has been quite active in several of Bowling Green's organizations. He has for years been an elder in the Cumberland

(Continued on Page 452)

EDITORIALS

From the Editor

INVARIABLY we view transitions with mixed emotions. Certainly the withdrawal of Mr. and Mrs. J. G. Denhardt as publishers of our Journal and the beginning of our association with the Gibbs-Inman Publishing Company is no exception.

With the loyal and effective cooperation of the Denhardts, our Journal has taken its place among the outstanding state medical Journals in the nation. Every KSMA member owes the Denhardts a debt of gratitude for their incomparable service. We are going to miss them.

The enthusiasm—the know how—the diversity of equipment our new publishers have make us look to the future with great hope that our Journal will continue to grow and become more profitable to our members as they seek to render to the people of Kentucky an ever improving type of medical service.

It would be most inappropriate to close this message without attempting to express our appreciation to the Advisory Committee to the Editor. Guy Aud, M. D., Chairman, and his group were delegated by the Council to select a new publisher and decide on a new Journal format. This committee has spent many hours carrying out this duty. We of the Journal staff are most grateful for this committee's splendid contributions.

Woodford B. Troutman, M.D.
Editor Pro tem

The Changing Face of Tuberculosis

A MARKED decline in the tuberculosis death rate in the past few years has misled many observers in the direction of complacency as to the size of the remaining public health problem offered by this disease. Between 1950 and 1954, a reduction of over 50 per cent in the number of tuberculosis deaths in Kentucky stands in contrast to a very modest decline of about 10 percent in the number of known active cases. Our new cases reported annually, after remaining almost constant for a three year period, dropped 14 per cent in 1955. However the bed occupancy rate of all our tuberculosis hospitals remains high.

Trends now well established are toward increased longevity of tuberculosis patients, and higher incidence and prevalence rates in the older age groups. In 1955 Kentucky's population aged 65 and over was eight percent of the total, yet accounted for 18 per cent of all newly reported cases of tuberculosis. Although senior citizens as a group are less responsive to the appeal of mass chest X-Ray surveys than younger persons, we have noted a substantial increase every year since 1951 in the number of newly reported active cases of tuberculosis in persons of 65 years or older. After age 50, new cases among males outnumber females by two to one. Another trend is toward mildness and extreme chronicity of the disease in these elderly patients, of such degree that death certificates may show degenerative conditions such as cardiovascular disease to be the primary cause of death.

Although they appear to be low, we should not be satisfied with current death rates from this disease, which even now kills more Kentucky citizens each year than all other infectious diseases combined. As Robert J. Anderson pointed out in a paper presented at the 1955 meeting of the National Tuberculosis Association, we shall need years of effort to bring the tuberculosis death rate to 1.5 per 100,000 population, the level of that for acute rheumatic fever, appendicitis, arthritis, and poliomyelitis, all of which are still regarded as of significance to the public health.

While tuberculous morbidity remains at a relatively high level, we should continue to search for and treat the active, infectious case.

We have hospital beds for less than one-third of active cases; the other cases constitute a major obstacle in the path of effective tuberculosis control. Treatment by chemotherapy, if continued for 12 months, shows clinical improvement in a majority of cases, with sputum reversal in over 80 percent. The chief objection raised against such a regime has been based on fear of the emergence of drug resistant organisms in patients so treated. However the Army-Navy-Veterans' Administration cooperative study showed only two per cent of patients who had developed this complication at the end of 12 months on INH-PAS.

It is realized that while many tuberculosis patients can and do pay for medical care, our problem of making effective use of treatment outside hospital as a potent weapon in tuberculosis control, remains inseparable from the still unsolved problem of medical care for the indigent.

PAUL M. CRAWFORD, M.D.

Adolescent Adults

WHY DO adults frequently ignore the advice that their trusted physicians have given them? Unsolicited they have come for help. Yet when the means of obtaining health are explained to them many will refuse to follow a regimen. Why? Often it means some sacrifice, usually of a habit that is contributing to their illness. Many of these patients are educated, cultured individuals, leaders in their community. They often are heads of large businesses. Some have families with growing children whose careers would be at stake if an overwhelming calamity struck them. And yet they will eat excessively, smoke excessively, and at times exercise excessively, even though the inevitable results have been explained. They do it fully conscious of the risk.

I have called this group "Adolescent Adults" because their reaction to the problem at hand is not that of a mature adult but rather of an adolescent. They are evasive, never quite honest, often acting as if they regard the advice to be sadistic in nature. They take the position that the hardships imposed on them give their doctor pleasure and consider the joke to be on him if they can get by without accepting his advice. I do not include in this group the true alcoholics who merit a pigeonhole all to themselves.

Many examples come to mind—too many to include here. A man in his early sixties, a heavy smoker of heavy cigars, hypertensive, with angina pectoris was advised to gradually quit his tobacco. He did, but was seen by one of his friends miles from his home standing in the vestibule of an old house smoking a cigar solo.

A case of duodenal ulcer that could easily be controlled by the usual routine, always recurred after going back to one or two packs of cigarettes a day, a few drinks of whiskey and coffee. A huge well-built athletic individual, head of a very large business, admitted to me the reason. All his life he had been able to do the things he wanted to and he never could accept the idea that his Achilles Heel lay just beyond his pylorus. He has had four or five recurrences of his ulcer and still thinks he should be able to lick it and do the things he enjoys.

The diabetics with coronary disease and obesity are always problems. Most of these people really want to live, yet when chided for not following a diet, losing weight or reducing their tobacco intake, I have seen men sulk like 16 year olds resisting correction. I am sure anyone who has practiced medicine any length of time can give detailed accounts of many similar cases. Theodore Roosevelt once said that all he got out of college was learning to do pleasantly the things he did not want to do. That, of course, is self discipline, one of the essentials of maturity.

The accelerated tempo of modern life often leads to a state of tension which may need an outlet in one of many directions. Frequently this results in a regression from mature adult behavior toward that of an adolescent. In refusing to face squarely and honestly the actual situation, the "Adolescent Adults" gamble with their very lives.

MORRIS FLEXNER, M.D.

Opinions expressed in contributions to this Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

ORGANIZATION SECTION

Gant Gaither, M.D., Reports on '56 Annual Meet Plans

Plans for the 1956 KSMA Annual Meeting in Louisville, September 18-20 are well advanced according to Gant Gaither, M. D., Hopkinsville, chairman of the Committee on Scientific Assembly.

Two new features are planned for the '56 meeting. One—refresher courses for physicians will be held each morning from 8 to 10. Carefully selected scientific movies will also be shown each morning.

Among the speakers at the meeting will be Frank L. McPhail, M. D., Great Falls, Montana and Wendell G. Scott, M. D., St. Louis, Missouri.



Dr. McPhail

Dr. McPhail, a graduate of the University of Michigan Medical School, is senior obstetrician and gynecologist at the Great Falls Clinic in Montana. Dr. McPhail, a past president of the Montana Medical Association, is a member of the American Association of OB-GYN, American Academy of OB-GYN and a fellow of the American College of Surgeons. He is chairman of the Western Interstate Commission on Higher Education.



Dr. Scott

Dr. Scott, associate professor of clinical radiology at Washington University School of Medicine, is associate radiologist to Barnes and Allied Hospitals in St. Louis. He is chairman of the Commission of Public Relations of the American College of Radiology and associate editor of the American Journal of Roentgenology, Radium Therapy and Nuclear Medicine. Dr. Scott is chairman of the Special Medical Advisory Group, Department of Medicine and Surgery, at the Veterans Administration in Washington, D. C.

AMA President-elect Speaks At CSOC March 29, Lexington

"Consider the patient a part of the problem and not apart from the problem," Dwight Murray, M. D., Napa, California, AMA President-elect told physicians at the County Society Officers Conference in Lexington, March 29. Dr. Murray was the luncheon speaker.

The morning session of the conference featured such outstanding public relations experts as:

Leo Brown, Director of AMA Public Relations who gave the results of a recent AMA poll answering the question "How Do You Rate Doctors?"

C. Allen Payne, M. D., Chairman of the PR Committee of the Michigan State Medical Society, told the group the greatest asset of the county medical society was young physicians who have just become members of a society.

Jerry Pettis, assistant to the President and PR Counsel of the Los Angeles County Medical Society, explained the "Way out of the Trap of Third Party Medicine."

Alfred Chadwick, M. D., member of the Pennsylvania State Medical Society's PR Committee, explained how doctors in small communities have fewer PR problems than those in cities.

The morning session was closed by a panel discussion featuring the morning speakers and moderated by C. C. Sparks, M. D., Ashland, Past-president of the KSMA.

Following Dr. Murray's luncheon address David Allman, M. D., chairman of the AMA Legislative Committee, speaking on medical legislation, told the guests, "a good doctor is likely to be a good civic leader." To be such, Dr. Allman said he must keep informed on legislation.

Mr. William McGrath, Cincinnati, Employer's Delegate to the International Labor Organization, closed the afternoon speaking session by denouncing the ILO. He said he had asked President Eisenhower to withdraw US representation to the organization.

Gant Gaither, President of the KSMA, presided over the morning session and Richard Slucher, M. D., Louisville, President-elect was presiding officer during the afternoon session. J. Vernon Pace, M. D., Paducah, Chairman of the KSMA Council, moderated a discussion that closed the day's program.







Hospital Accreditation Board Announces New Standards

A new edition of the "Standards for Hospital Accreditation" was approved January 28, 1956 by the Board of Commissioners of the Joint Commission on Accreditation of Hospitals. The announcement was made by Kenneth B. Babcock, M. D., Director.

Five changes which are of interest to physicians are:

1. The requirement that all patients have a serological test for syphilis on admission has been dropped. It is now optional with the hospital.

2. After investigation and consultation with the American Academy of OB-GYN, it was decided that recorded pelvic measurements on obstetrical patients would no longer be required.

3. A recording thermometer on the discharge line of every autoclave is no longer required *but* the requirement that cultures be done at least monthly is still in effect.

4. An automatic stop order on dangerous drugs has been added. The hospital staff will determine the limit and the drugs to be included.

5. A written plan for the reception and care of mass casualties is required. For help in developing such a plan the American Hospital Association has published two booklets—"Principles of Disaster Planning" and "Readings in Disaster Planning for Hospitals." These can be purchased from the AHA.

1956 County Society Officers Conference

(TOP) Top KSMA officials got together at the County Society Officers Conference March 29 with the new Kentucky Health Commissioner, Russell Teague, M. D., second from left. Others pictured are (l to r) Gant Gaither, M. D., President of the KSMA; Dr. Teague; J. Vernon Pace, M. D., Chairman of the KSMA Council; and Richard Slucher, M. D., President-elect of the KSMA.

(MIDDLE) These men participated in the panel discussion at the close of the morning session of the Conference. Standing (l to r) Mr. Leo Brown, PR Director of the AMA; Mr. Robert Enlow, director of AMA Membership-Circulation Department; and Clyde C. Sparks, M. D., Past President of the KSMA, moderator. Seated (l to r) C. Allen Payne, M. D., chairman of the PR Committee of the Michigan State Medical Society; Mr. Jerry Pettis, assistant to the President and PR Counsel of the Los Angeles County Medical Association; and Alfred Chadwick, M. D., member of the PR Committee of the Pennsylvania State Medical Society.

(BOTTOM) When Presidents get together... Pictured are Dwight Murray, M.D., President-elect of the AMA; Gant Gaither, M.D., President of the KSMA; Mrs. R. Ward Bushart, President of the Woman's Auxiliary to the KSMA; Mrs. R. Ward Bushart, President of the Woman's Auxiliary to the KSMA; John Sprague, M.D., President of the Fayette County Medical Society and Robert Overstreet, President of the Louisville Chapter of the Student AMA.

Hospital staffs wishing to know more about hospital accreditation, standards can procure four publications on the subject. These booklets can be purchased from the Joint Commission on Accreditation of Hospitals, 660 North Rush Street, Chicago. The names and prices of the publications are: "Standards for Hospital Accreditation" and "Principles for Establishing Medical Staff Bylaws, Rules and Regulations," both 25 cents per copy. Survey Report Forms, 50 cents per copy and "Bylaws of the Joint Commission on Accreditation of Hospitals," 10 cents per copy.

In 1954 there were 2,928 fully accredited hospitals. This number grew to 3,102 in 1955.

AMA President Hess Speaks At Second Annual Senior Day

"I can't see how any man can practice medicine without a great belief in a Creator," Elmer Hess, M. D., Erie, Pennsylvania, President of the AMA, told seniors medical students from U of L at the dinner at the Second Annual Senior Day, April 16 at the Kentucky Hotel in Louisville.

The program, an attempt to bridge the gap between academic and applied medicine, is sponsored by the KSMA, the University of Louisville School of Medicine and the Jefferson County Medical Society.

"There comes a time," said Dr. Hess, "when science isn't worth a damn." At that time the doctor "must take his patient over that last hurdle with faith, hope and courage."

Dr. Hess, in explaining the AMA function to the students said "It is a federation of state medical societies. Only at the county society level can a man be disciplined or can something start. It's the only organization I know of that gets its orders from the grass roots."

Bill VonderHaar, Louisville, President of the University of Louisville senior medicine class, described the day long program as "most beneficial."

At an afternoon meeting Dr. Hess spoke to the wives of the U of L seniors. He told them they could be "the greatest public relations exponent in the medical field."

Dr. Hess' dinner speech climaxed the day's program which included talks and discussions by some of Kentucky's most outstanding physicians. Speakers were: Gant Gaither, M. D., Hopkinsville, KSMA President; Richard G. Elliott, M. D., Lexington; Oscar Hayes, M. D., Louisville; H. Burl Mack, M. D., Pewee Valley, 1955 President of the Kentucky Chapter of the AAGP; Crocker Clegg, M. D., Elizabethtown; Lawrence T. Minish, M. D., Louisville; Carroll T. Witten, M. D., Louisville, editor of the KAGP Journal; John B. Floyd, Jr., M. D., Lexington; Paul Sides, M. D., Lancaster; Glenn Bryant, M. D., Louisville; Homer Martin, M. D., Louisville; W. Vinson Pierce, M. D., Covington, KSMA delegate to the AMA; Robert Long, M. D., Louisville; Arthur Hurst, M. D., Louisville and Irving Abell, Jr., M. D., Louisville, President of the Jefferson County Medical Society.

The seniors were individual guests of members of the JCMS at the joint meeting and dinner session.

Commencement P-G Course Planned in Louisville, June 4

The University of Louisville School of Medicine in cooperation with the Kentucky State Medical Association and the Kentucky Chapter of the American Academy of General Practice, will sponsor a Commencement Post-Graduate Seminar at the Rankin Amphitheatre of the Louisville General Hospital, Monday, June 4.

All physicians are invited to attend the meeting which will feature the following program:

8:00 a.m. **Registration**

8:45 a.m. **Welcome**
J. Murray Kinsman, M.D., Dean of the UL Medical School

9:00 a.m. **"Estimation of Pelvic Capacity"**
Douglas Haynes, M. D.

9:45 a.m. **"The Pathogenesis of Arterio-Sclerosis"**
W. M. Christopherson, M.D.

10:30 a.m. **"The Recognition and Management of Hyperthyroidism"**
Beverly T. Towery, M. D.

11:30 a.m. **Elective Tour**

1:00 p.m. **Lunch (Jewish Hospital) Greetings**
Philip Davidson, Ph. D., President, U of L

2:30 p.m. **"Office Practice of Physical Medicine and Rehabilitation**
Rex O. McMorris, M. D.

3:15 p.m. **"The Normal Pattern of Growth in the Child"**
Frank Falkner, M. D.

4:00 p.m. **"Optimal Times for Electic Pediatric Surgical Procedures"**
Hugh Lynn, M. D.

5:00 p.m. **Social Hour**
John Walker
Moore Lounge
Medical School Building

Consulting Architects Named For U of K Medical School

A St. Paul, Minnesoto firm has been engaged as consulting architects for the proposed medical school at the University of Kentucky according to the Lexington Leader. The firm designed Mayo Clinic.

Governor Chandler said at the recent Kentucky Public Health Association convention he expected the first class to enroll in the school in 1959. He said the State would put $11,000,000 into its budgets over the next four years. "We'll get $11,000,000 (more) someplace else," he said.

The proposed center will be located on a 39 acre plot of land on the Kentucky agricultural station farm near the intersection of South Limestone and Rose Streets in Lexington. This decision, according to published reports, was made at the April meeting of the UK Board of Trustees.

Dr. Herman L. Donovan, UK President, said Vernon Lippard, M. D., dean of the Yale University Medical School, is advising the University on how to organize a medical school. Dr. Donovan said Dr. Lippard volunteered his assistance. Dr. Donovan further said a dean of the proposed school has not yet been named.

PG Course to End June 19

The Pediatrics Post Graduate Course, sponsored by the KSMA in cooperation with the University of Louisville School of Medicine and the Kentucky Child Health Foundation, which began May 1 at Children's Hospital in Louisville will continue through June 19.

Alex Steigman, M. D., Louisville pediatrician, director of the course, said the meeting dates are May 15, 22, 29 and June 5, 12 and 19.



Elmer Hess, M.D., Erie, Pennsylvania, President of the AMA, jokes with two future doctors at the second annual Senior Day April 16 in Louisville. The U of L senior medical students are Gene T. Watts, Hindman and Bill Vonder Haar, president of the senior medical class.

Hoxsey Treatment is Worthless Says Food-Drug Administration

The United States Court of Appeals for the Fifth Circuit, on the basis of evidence presented by the Food and Drug Administration, has warned the public that the Hoxsey Cancer Treatment is worthless, and can in some cases actually speed the growth of cancer. The announcement, which was made in the Federal Register April 7, 1956, is published at the request of Russell Teague, M. D., Kentucky Commissioner of Health.

The treatment, which costs $400 plus $60 in additional fees, is available in two places in the United States—Dallas, Texas and Portage, Pennsylvania. At both places potassium iodide is used in the treatment. The FDA Report said "There is evidence that the potassium iodide accelerates the growth of some cancers."

The FDA after a thorough investigation, said they had not found a "single verified cure of internal cancer effected by the Hoxsey treatment." The National Cancer Institute of the USPHS reviewed case histories submitted by Hoxsey and told him they found no scientific evidence that his treatment has any value in the treatment of internal cancer.

In his Texas clinic, Hoxsey said the FDA document was libelous and stated he'd make arrangements for a lawsuit in Washington. He said, according to published reports, the government has never made a full investigation.

A leaflet on mechanical quackery has been issued by the AMA's Bureau of Investigation. The pamphlet, is designed to help the public identify some of the devices, etc., used for so called "cures" and "treatments." Physicians can purchase these leaflets directly from the Bureau.

Expanded Medical Center Is Proposed for Louisville

Plans for a proposed medical center in Louisville were recently discussed at the City Hall, according to published reports.

The plans, prepared by a St. Louis firm, center around three hospitals—General, Children's and Jewish. It adds:

1. Three more proposed hospitals
2. Expansion of the three already mentioned hospitals
3. A new U of L Medical and Dental School building
4. Home for student nurses
5. The physicians' office building at Floyd and Gray
6. A Rehabilitation Center
7. The City-County Health Department will be moved to 316 E. Chestnut
8. Shopping center, apartments for Medical Center physicians and employees plus many parking lots
9. Abandonment of George W. Morris School
10. Possible building of a U of L School of Pharmacy and Medical Center research laboratory

Gov. Chandler is Guest Speaker At Eighth Annual KPHA Meeting

Governor A. B. Chandler was a guest speaker at the Eighth Annual Meeting of the Kentucky Health Association and Official Conference of Public Health Workers in Louisville, March 21-23.

Russell Teague, M. D., Kentucky Health Commissioner, since February 15, in his first speech since being appointed, told the convention-goers that more



"Now this is how we handle it in Pennsylvania," Alfred Chadwick, M.D., member of the PR Committee of the Pennsylvania State Medical Society, seems to be telling this group of PR men at the County Society Officers Conference. Listeners are (l to r) Richard Slucher, M.D., President-elect of the KSMA; Leo Brown, PR Director of the AMA; C. Allen Payne, M.D., chairman of the PR Committee of the Michigan State Medical Society and Richard Elliott, M.D. Chairman of the KSMA Committee on Public Information and Service.

money must be found to finance local health departments.

Walter L. O'Nan, M. D., Henderson, KSMA councilor from the Second District, participated in a panel session concerning the nutrition program in Henderson schools.

Miss Virginia Dodd, Irvine, took over the office of President of KPHA and Edgar Hume, Frankfort was named President-elect. Other officers are: Charles E. Acuff, supervisor of school health for the State Health Department, vice-president; and Orman Wright, Jr., executive assistant to the State Health Commissioner, secretary-treasurer.

The KPHA constitution was amended to allow anyone interested in public health to become a member and hold office. Before active membership has been restricted to employees of State or local health departments.

Sixth District Physicians Hear Dr. Gaither and Dr. Regen

The Sixth Councilor District of the KSMA met at the Helm Hotel in Bowling Green, March 13. Warren County Medical Society was the host society according to L. O. Toomey, M. D., Bowling Green, Councilor from the District.

Eugene Regen, M. D., Nashville, was the scientific speaker for the evening. He spoke on lateral scoliosis of the spine. Gant Gaither, M. D., KSMA President, spoke on medical legislation.

The Barren County Society will be the host at the June meeting of the district.

Kentucky physicians and their wives who are planning to attend the AMA Annual Meeting in Chicago June 11-15 are invited to tour the Association's headquarters at 535 North Dearborn on Grand Avenue. Specially trained guides will conduct tours through the building from 9 a.m. to 4 p.m. Monday through Friday.

MD From Cabbage Patch Is "Family Doctor of the Year"

Arthur Ouchterlony Goodman, M. D., Louisville, was named "Family Doctor of the Year" at the annual meeting of the Kentucky Chapter of the American Academy of General Practice in Louisville, April 18-20.

Dr. Goodman, who has practiced medicine in the Cabbage Patch area of Louisville for 41 years is a graduate of the University of Louisville School of Medicine. A general practitioner, Dr. Goodman holds an instructorship in community health at U of L. He is former director of communicable-disease control for the City-County Health Department.

Julian Cole, M. D., Henderson, is the new president of the Academy. He succeeds H. Burl Mack, M. D., Pewee Valley. W. E. Bechnell, M. D., Manchester, is the new president-elect. Other officers elected were: Eugene M. Holmes, M.D., Middletown, vice-president; Keith Smith, M. D., Corbin, secretary-treasurer; and Frank L. Duncan, M. D., Monticello, delegate to the AAGP.

Elmer Hess, M. D., Erie, Pennsylvania, President of the AMA, was guest speaker, Tuesday, April 17.

Fulton's Dr. D. L. Jones Named "1955 Citizen of the Year"

David Lonzo Jones, M.D., a practicing physician in Fulton for 50 years, was recently named "Citizen of the Year" by the Fulton County News and radio station WFUL.

Gant Gaither, M. D., Hopkinsville, KSMA President, represented the medical profession from Kentucky at the dinner party based on the TV program "This is Your Life."

Senator Earle C. Clements presented Dr. Jones a gold loving cup as a memento of the occasion.



Charles Vance, M.D., (left), Speaker of the KSMA House of Delegates and Woodford B. Troutman, M.D., (right), Secretary-Editor Pro tem of the KSMA tell an interested Californian, Jerry Pettis the history of Ephraim McDowell, M.D., famous Kentucky physician. Mr. Pettis, assistant to the President and PR Counsel of the Los Angeles County Medical Association, was a guest speaker at the County Society Officers Conference in Lexington, March 29.

Notes on the Diagnosis and Management of "Dizziness"

III. Ménière's Syndrome





1. Paroxysmal Whirling Vertigo. *This consists of sudden attacks of dizziness, often when the patient is at rest or asleep. The patient may feel that he himself is whirling or that fixed objects about him are whirling. The attack usually lasts for a few minutes; occasionally it is severe for weeks or subacute for months.*



2. Subtotal Hearing Loss. *Deafness will usually affect the high tones and it may be unilateral or bilateral. Sometimes the hearing loss is severe and also progressive.*

3. Tinnitus. *This is usually unilateral and present in the ear with greater hearing loss and is without a definite pattern.*



Fewer diagnostic errors[1] will result if a "triad of symptoms" is required of patients with suspected Ménière's syndrome. These are the symptoms of typical Ménière's syndrome:

1. Severe paroxysmal vertigo which may be of two types; either the patient feels that he is whirling or that objects about him are whirling.
2. Fluctuating subtotal hearing loss, usually affecting the higher tones, is noted at the same time as vertigo.
3. Tinnitus, usually unilateral, is associated with the deafness and dizziness.

With Ménière's syndrome there is no definite localization[2] by the Bárány (vestibular reaction) test and results of the caloric test are not diagnostic. Physical examination should rule out disease of the central nervous or cardiovascular systems before a diagnosis is made.

"Treatment with Dramamine®. . . is effective[3] in aborting and preventing attacks of Ménière's syndrome . . . will prevent or arrest attacks of vertigo. It will also reduce the intensity of the tinnitus and so may save some of the hearing in the affected ear."

Dramamine is recommended for Ménière's syndrome as the sole therapy or in combination with other treatment programs.

It is a therapeutic standard also for motion sickness and is useful for relief of nausea and vomiting of radiation sickness and fenestration procedures.

Dramamine (brand of dimenhydrinate) is supplied in tablets (50 mg.); Supposicones® (100 mg.); ampuls (250 mg.); liquid (12.5 mg. in each 4 cc.). G. D. Searle & Co., Research in the Service of Medicine.

1. DeWeese, D. D.: Symposium: Medical Management of Dizziness. The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.
2. Jackson, C., and Jackson, C. L. (editors): Diseases of the Nose, Throat, and Ear, Philadelphia, W. B. Saunders Company, 1945, pp. 368; 414.
3. Queries and Minor Notes: Ménière's Syndrome, J.A.M.A., *141*:500 (Oct. 15) 1949.

A new edition of "Dramamine Reviews and Abstracts," containing digests of more than 100 recent articles, is available on request to . . . SEARLE P. O. Box 5110, B Chicago 80, Illinois



David Allman, M.D., (second from left), chairman of the AMA Legislative Committee, explains the recent happenings on Capitol Hill to this interested group at the County Society Officers Conference in Lexington, March 29. Listening are (l to r) Thomas P. Leonard, M.D., Chairman of the KSMA Legislative Committee; Dr. Allman, J. Vernon Pace, M.D., Chairman of the KSMA Council; Mr. William McGrath, CSOC speaker and employer's delegate to the International Labor Organization and Woodford B. Troutman, M.D., Secretary-Editor Pro tem of the KSMA.

J. F. Blackerby, director of vital records for the Kentucky State Health Department was recently awarded a 30 year service certificate by the Public Health Conference on Records and Statistics. Mr. Blackerby is a charter member of the American Association of Registration Executives. He has been the association's president twice.

The AMA's annual National Medical Civil De-fense Conference will be held Saturday June 9 at the Palmer House in Chicago. A feature of the conference will concern the operation of the Federal Civil Defense Administration's 200-bed emergency civil defense hospital. Also on the program will be films on medical subjects related to CD and talks by CD authorities.

Upjohn
KALAMAZOO

Indicated
in most conditions
in which oral cortisone
or hydrocortisone is effective
• Available in 1 mg. and 2.5 mg.
tablets in bottles of 100, and in 5 mg
tablets in bottles of 30, 100, and 500 •
Usual dosage is ½ to 1 tablet three or four
times daily

Delta-Cortef*

requires only 1/3 the dose of hydrocortisone

*Trademark for the Upjohn brand of prednisolone (delta-l-hydrocortisone)

CORRECT
CONSTIPATION...
RESTORE
HABIT TIME
OF BOWEL
MOVEMENT
PETROGALAR®

Aqueous Suspension of Mineral Oil, Plain

Bottles of 1 Pint



Wyeth®
Philadelphia 1, Pa.

New KSMA Members

The following physicians were recently added to the KSMA membership roster:

William Curtis Adams, M. D., Louisville
B. F. Allred, M. D., Albany
Orville L. Ballard, M. D., Waverly Hills
Clem F. Burnett, M. D., Mayfield
Fred J. Cecil, M. D., Horse Cave
Clarence Claugus, M. D., Louisville
J. F. Coulter M. D., Mayfield
V. L. Fisher, M. D., Sturgis
David M. L. Greely, M. D., Harlan
B. D. King, M. D., Hopkinsville
Ann L. Martin, M. D., Cumberland
Galen F. Scudder, M. D., Pine Mountain
A. Silins, M. D., Hopkinsville
Walter Thompson, M. D., Louisville
Harry U. Whayne, M. D., Murray
Earl R. Williams, M. D., Stearns
E. L. Woolsey, M. D., Harlan

Commission Appointed

C. C. Howard, M. D., Glasgow, has been named chairman of the recently appointed State Tuberculosis Sanatoria Commission. Fred Moffatt, M. D., Frankfort, is vice-chairman.

Other members of the commission, which was appointed by Governor A. B. Chandler, are Alec Spencer, M. D., West Liberty and V. A. Jackson, M. D., Clinton.

Flying Physicians to Organize

A Louisville area chapter of the Flying Physicians Association will be organized May 17 at 8 PM at the River Road Country Club.

Those eligible for membership are physicians who have a private pilot certificate or better and a physical examination currently enforced. For more complete information contact M. A. Bowers, Jr., M. D., 2418 Cross Hill Road, Louisville.

Dr. Love Speaks at KSDA Meet

Jesshill Love, M. D., Louisville, was the guest speaker from the KSMA at the 1956 annual meeting of the Kentucky State Dental Association in Louisville, April 8-11. Six hundred and forty-three members were registered. (There are 868 KSDA members.)

According to Bing Coxwell, D.D.S., Louisville, KSDA Secretary, Arthur Elam, D.D.S., Lexington was installed as president. J. J. Kelly, D.D.S., Franklin, was named president-elect.

Pediatricians Hear Dr. Hodes

Horace L. Hodes, M. D., clinical professor of pediatrics at Columbia University College of Physicians and Surgeons spoke at the annual meeting of the Kentucky Pediatric Society in Louisville, April 5. Dr. Hodes spoke on virus diseases of the eyes, nose and throat and on infant diarrhea.

Dr. Fountain Joins UL Staff

Freeman Fountain, M. D., will become assistant to the medical director of the Louisville Rehabilitation Center and assistant professor of Physical Medicine and Rehabilitation at the University of Louisville on July 1.

A '51 graduate of the University of Colorado Medical School he served three years in the Hospital Corps of the Naval Corps of the United States Naval Reserve. He served an internship at Fitzsimmons Army Hospital in Denver. Dr. Fountain, a diplomate of the National Board of Medical Examiners, was Medical Officer in the Pulmonary Disease Section at Fitzsimmons in 1951-52.

Surgeons Meet in W Virginia

Two Kentucky physicians participated in the program at the recent South Eastern Surgical Convention at White Sulphur Springs, West Virginia. They were R. J. Noer, M. D., Louisville and James B. Holloway, M. D., Lexington.

Mrs. Clyde C. Sparks, Ashland, wife of the 1955 KSMA President, was named president of the Woman's Auxiliary to the SES. Dr. Sparks is Councilor from Kentucky. The '57 meeting will be held in St. Petersburg, Florida on April 1.

VA Asks Support of MDs

H. W. Baxley, M. D., manager of the Huntington, West Virginia Veterans Administration Hospital, released a statement recently pertaining to patient admission in a VA hospital. Often the hospital is unable to determine the patient's medication prior to his admission, therefore "the local physician should give the person who transports him a brief statement as to the medication the patient has had."

D. L. Tynes Named BC Officer

D. Lane Tynes, executive director of the Kentucky Blue Cross Plan, was elected treasurer of the Blue Cross Commission of the American Hospital Association, April 12.

The Commission is the national co-ordinating agency of the 86 Blue Cross Plans in America, Canada and Puerto Rico. The Kentucky Plan, which Mr. Tynes heads, has over 586,060 members.

Dr. Dillard Heads KAPHP

Harry K. Dillard, M. D., Lexington, city-county health officer, was named president of the Kentucky Association of Public Health Physicians formed during the annual KPHA meeting in Louisville, March 21-23.

Other officers elected were: A. W. Andreasen, M. D., Somerset, president-elect; Mildred Gabbard, M. D., Booneville, vice president; and Judith Stout, M. D., secretary-treasurer.

SUDDENLY IT'S SPRING!

Why Not Spruce Up Your Office This Spring With A New Hamilton Suite From CROCKER-FELS?



If you're looking for an unusually attractive examining room suite, unusually serviceable equipment, and special features to make your work easier—you'll find them in Hamilton's Steeltone, shown above. And it's available in an array of decorators' colors: white deluxe, cream white, jade green, washington blue, coral, and silver metallic.

The name Hamilton is synonymous with quality.

The Crocker-Fels Company

624 S. THIRD ST. CLay 8855 LOUISVILLE, KY.

Ask about our liberal financing plan



Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

C I B A
Summit, N. J.

2/2228M

AMA Announces Establishment Of New Advisory Committee

A Physicians' Advisory Committee for TV, Radio, and Motion Pictures has been formed by the American Medical Association.

The purpose of the committee is to assist network script—supervisors, producers and writers in the preparation of TV and radio programs on medical subjects.

This type of service has been carried on in the past through the office of the AMA's Bureau of Health Education.

Leo Brown, AMA Public Relations director and guest speaker at the 1956 KSMA County Society Officers Conference said the plan was a further "effort to insure technical accuracy in TV and radio programs centering about medicine and the profession."

Dr. Brodsky Gets AHA Grant

W. A. Brodsky, M. D., associate professor of pediatrics at the University of Louisville School of Medicine, recently was awarded one of the 131 research grants given by the American Heart Association. He received $6,500.

Last year Dr. Brodsky received $6,000 for his research which concerns the action of the kidneys and changes in salt and water balances in the body that affect many body organs, including the heart.

News Items

Auddie C. Kennedy, M.D., a 1954 graduate of the University of Louisville School of Medicine, has opened a practice in Valley Station. Dr. Kennedy, who interned at Good Samaritan Hospital in Lexington, has practiced in Hardinsburg since July 1955.

Donald Cantley, M.D., a pediatrician, has begun a practice in Henderson. Dr. Cantley, a '51 graduate of the Medical College of Alabama served his internship and residencies at the Lloyd Noland Hospital in Fairfield, Alabama and the Children's Hospitals in Birmingham and Cincinnati.

Ethel O'Brien, M.D., Louisville child psychiatrist, has been appointed supervisor of the children's unit of the State Mental Health Department. Dr. O'Brien was graduated from the University of Louisville School of Medicine and interned at the Louisville General Hospital. She served a residency at Worcester State Hospital in Worcester, Massachusetts. Dr. O'Brien did post graduate work at Yale University in New Haven, Connecticut. She conducted a private practice in New Haven also.

William S. Snyder, M.D., Frankfort EENT specialist, has been elected governor of the 33rd district of Rotary Clubs. Dr. Snyder, a 1926 graduate of Rush Medical College, is a former president of the Kentucky EENT Society and the Franklin County Medical Society.

Gay Morrow, M.D., has been named associate chief of anesthesiology at Harlan Memorial Hospital. A graduate of George Washington University School of Medicine, Dr. Morrow has been associate chief anesthesiologist in the Veterans Administration Center, Los Angeles and anesthesiologist at the Neuropsychiatric Hospital in Los Angeles. While in the army he served as chief of anesthesiology at Fort Ord and Camp Stoneman, California.

R. Moore Dodrill, M.D., has joined the staff of the UMW Hospital at Harlan. Dr. Dodrill was graduated from the University of Cincinnati School of Medicine in 1944. He took his hospital training at Mercy Hospital in Chicago, Chesapeake and Ohio Employer's Hospital in Huntington, West Virginia, University of Pennsylvania and Bryn Mawr Hospital.

Charles Neil Christensen, M.D., a native of South Dakota, has joined the staff of the UMW Hospital in Pikeville. Dr. Christensen, a pediatrician, was graduated from the Pennsylvania School of Medicine in 1945. He had his hospital training at the University of Pennsylvania Hospital. Dr. Christensen served some time in the U. S. Navy.

Clarence J. Kasales, M.D., a pediatrician, has joined the staff of the UMW Hospital in McDowell. Dr. Kasales, a native of Pennsylvania, is a '46 graduate of Temple University. He had his hospital training at Allentown General Hospital, Harvard University, Abington General Hospital and Mayo Clinic. He has served in the U. S. Navy.

The End of An Era

(Continued from Page 438)

Presbyterian Church and in 1954 retired as chairman of the Board of the Salvation Army. He is still a member of the Kiwanis and recently resigned from the Bowling Green Board of Education.

According to the Park City News, Bowling Green's present daily newspaper, Mr. Denhardt has for the past six or seven years given a turkey dinner at Christmas to the fire department. He does this "for a favor they did me once."

It all began one day when the building next door to the Times Journal caught on fire and burned to the ground. Mr. Denhart explained that for the third time in his life it looked as if his business was going to burn. "But because of the firemen only our wall was a little scorched." Since that time Mr. Denhardt has given the Christmas dinner, "as a sort of thanks." Last year over 60 people including the police department attended.

When you talk to the Denhardts it is evident that they have not only published a medical



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Member of the American Hospital Association and National Association of Private Psychiatric Hospitals

Four modern buildings, separate for men and women Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD, Hospital Administrator

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M.D., Neuropsychiatrist Medical Director

T. J. SMITH, M.D., Associate

All the benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress



Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra' are designed to help the physician cope with the problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids prednisone and prednisolone. Each Multiple Compressed Tablet is specifically formulated as a "tablet within a tablet" to provide stability and to release in sequence antacid and anti-inflammatory components.

NEW

'Co-Hydeltra'

Prednisolone Buffered

and

'Co-Deltra'

Prednisone Buffered

MULTIPLE COMPRESSED TABLETS

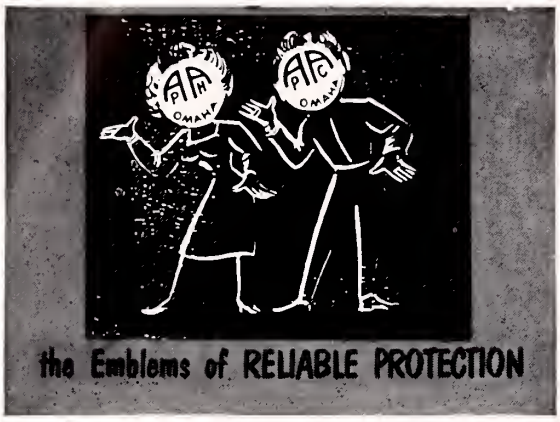
Supplied: Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra', each containing 5 mg. prednisone or prednisolone, 300 mg. of dried aluminum hydroxide gel, U.S.P., and 50 mg. of magnesium trisilicate, U.S.P., bottles of 30 tablets.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

'Co-Deltra' and 'Co-Hydeltra' are the trademarks of MERCK & CO., INC.

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your eligible dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$23,800,000 PAID FOR BENEFITS SINCE ORGANIZATION

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

journal for the past 50 years but have lived it—it has been their life. "Guess I've read as much medicine as any man in Kentucky", Mr. Denhardt jokes.

The Denhardts have not worked for an association only, but have gone out and made friends of that association's members. Mr. Denhardt speaks proudly of his close friendship with many of Kentucky's physicians.

Perhaps the Denhardts' feeling toward the Journal can be summed up in a statement made by Mr. Denhardt. "To give up the Journal is like losing a member of our family. It has been a part of us for so long it will not seem right without it."

And after all these years it will not seem right without the Denhardts either.

A Note from the Denhardts

As we relinquish the publishing of the Kentucky State Medical Association's Journal we wish to express to the Managing Editor and his staff and the members of the Council and to all who have worked with us throughout the years our sincere appreciation for the splendid support and cooperation you have given us throughout the many years that we have been given the opportunity to have a part in putting in print this important publication.

This with us has not been just another job, but we have become attached to this Journal and have strived in trying to make it better and more typographically errorless each month.

We have tried to keep in close touch with aims and efforts put forth by the officers and members of the State Medical Association by attending its state meetings and keeping in touch with the very worthwhile activities that this splendid public spirited group is carrying on for the betterment of the masses of our citizens of our state.

We have been connected with the publication of the Journal so long that it is with sincere regret that we feel now that we should sever our part as its publishers.

We have watched its growth from a very small publication until now it has become one of the leading state medical journals in our nation.

Mr. Denhardt wishes to take this opportunity to state that no man ever had a wife who proved such a real helpmate and who

had taken such a keen interest in her husband's undertakings. She, it is, who has read and re-read the proofs and supervised the makeup of pages and has kept her medical directory close at hand as a guide. Mr. Denhardt knows that to her is due the major credit for whatever success we have achieved as publishers of the Journal.

Wishing the Journal and the officers and members of the KSMA much success in their worthwhile activities and expressing our appreciation for the many courtesies shown us—

Very sincerely,

Mr. and Mrs. J. G. Denhardt

Case Discussion

(Continued from Page 436)

actions have been reported. The oral dosage is 100 to 300 mgm. per kilogram daily. This drug may give disturbing but harmless blue urine and stool.

QUESTION: What are the physiological effects of methemoglobinemia?

Doctor Steigman: The oxygen in methemoglobin is so firmly bound that methemoglobin cannot function as an oxygen carrier. The symptomatology may be due to hypoxemia and/or to the side effects of the substance causing the methemoglobinemia. In addition to the peculiar bluish-grey cyanosis, there may be drowsiness, increased respiratory rate, and tachycardia. A gastrointestinal upset is frequently associated with methemoglobinemia.

QUESTION: What types of water supply are most likely to have a high nitrate content?

Doctor Steigman: The most frequent type is the dug well which is close to sources of pollution. Frequently the wells are shallow, poorly constructed, situated on low ground, and in close proximity to a manure pile or pig pen.

QUESTION: What can we as physicians do to prevent this type of poisoning in infancy?

Doctor Steigman: 1. Cooperate with the Public Health Department in providing better water supplies, especially in the rural areas.

2. Educate the public as to the danger of using nitrate-containing water for artificial feeding in the first few months of life.

3. Report to the State Board of Health cases of methemoglobinemia due to nitrate ingestion. Since it is not a reportable disease the true incidence is not known.

EVERY WOMAN

WHO SUFFERS

IN THE

MENOPAUSE

DESERVES

"PREMARIN"®

widely used

natural, oral

estrogen

AYERST LABORATORIES

New York, N. Y. • Montreal, Canada

• 5645

NEW CASTLE SANITARIUM

Telephone 3621

NEW CASTLE, KY.

For the care of

CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the American Hospital Association
Member of the American Assn. of Nursing Homes
Licensed and Approved by the State of Kentucky

SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE

PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS

24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES
New Selectemp Moduloted Steam Heat With Filtered Air For Maximum Comfort and Safety
Protected Throughout With Automatic Fire Detection and Alarm System

IRA O. WALLACE, Administrator

*"...THE MERCURIALS HAVE PROLONGED THE WORKING PERIOD AND LIFE SPAN OF COUNTLESS SUFFERERS FROM CONGESTIVE HEART FAILURE..."**

TABLET
NEOHYDRIN®

*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

00756

CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of mental and nervous disorders, and addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director

Introducing

A.P.C. WITH Demerol® Tablets

for more efficient

CONTROL OF *Pain*

Each tablet contains:

Aspirin	200 mg.	(3 grains)
Phenacetin	150 mg.	(2½ grains)
Caffeine	30 mg.	(½ grain)
Demerol hydrochloride	30 mg.	(½ grain)

Average Adult Dose: 1 or 2 tablets
repeated in three or four hours as needed.

Bottles of 100 tablets. *Narcotic blank required.*

"Such a combination has proven clinically to be far more effective and no more toxic than equivalent doses of any of these used singly."*

Winthrop LABORATORIES
NEW YORK 18, N. Y.

*Bonica, J.J.; and Backup, P.H.: Northwest Med., 54:22, Jan. 1955.

Demerol, trademark reg. U.S. Pat. Off., brand of meperidine. – May be habit forming



The above advertisements appeared recently in Life, Saturday Evening Post, and Today's Health.

"How to look at a doctor's bill" could well serve as the title for recent Parke-Davis advertisements on the cost of medical care. For they suggest to the public new ways of looking at the extraordinary *value* one buys with each dollar spent for prompt and proper medical care.

These Parke-Davis messages talk in everyday language about familiar but "forgotten" facts. Some examples: the steadily decreasing cost of curing diseases such as pneumonia, the phenomenal reduction in the death-rate for children, the substantial savings in time and income because of the shortened duration of hospital stays.

By highlighting the heartening facts of medical progress in relation to the cost of medical care, this new series hopes to help in creating a healthy, realistic public opinion on the reasonableness of medical costs.

To do this successfully, we wish the facts to have the widest possible readership. Therefore these advertisements are being published regularly in such mass-circulation magazines as LIFE, the SATURDAY EVENING POST, and TODAY'S HEALTH.

If you would like to have folder-size reprints of any of these ads for your reception room, we will be happy to supply them on request.





PARKE, DAVIS & COMPANY

Detroit 32, Michigan

Adequate Hospitalization for Treatment of Alcoholics

Doctors find the modern facilities and specialized care available at White Cross Hospital meet a vital need.

Affords Sympathetic Atmosphere, Encouraging Personal Attention, Specially Trained Staff

It is generally believed that alcoholism is self-imposed. Often in general hospitals the alcoholic patient is not considered to be "legitimately" sick, which results in the wrong psychological and emotional atmosphere that aggravates the condition. This is why more and more doctors with alcoholic cases where hospitalization is essential are utilizing the facilities at White Cross Hospital, devoted to the treatment of alcoholics exclusively. Here a sympathetic, comfortable and pleasant atmosphere—so essential to rehabilitation—is assured. The White Cross staff, trained in the special problems of the inebriate, is adequate to assure prompt attention at all hours. The White Cross Hospital is under the direction of a com tent licensed physician, with five consulting ph cians subject to call. Registered nurses and tec cians are in charge 24 hours daily.

Safe, Effective White Cross Treatme

A private hospital offering scientific, institutio medical, psychological, reflex, reduction and o methods for the rehabilitation of consent pati suffering from alcoholism. With the consent of doctor and patient, the regular White Cross cedure is followed. At your request, your pat remains entirely under your supervision. You come and go in White Cross Hospital at will, will find the staff completely cooperative. Y recommendations will be followed to the le

All equipment modern with facilities to care of 50 patients both male and female.



Salem, Va. Hospital

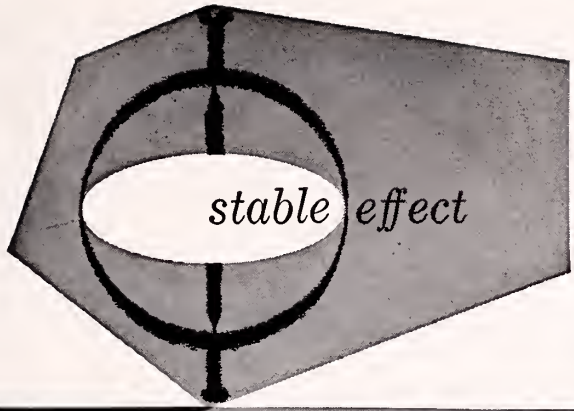
Approved and licensed by the Virginia State Hospital Board, Member American Hospital Association. Located atop beautiful Mt. Regis, in the quiet serene mountains of Virginia—conducive to rest, comfort and rehabilitation.

For information phone or write for booklet
Rates Reasonable

WHITE CROSS HOSPITAL

Five miles west of Roanoke on route No. 11
Salem, Virginia—Phone Salem 4761

Copyright 1955 H.N. Alford, Atlanta



RAUDIXIN

SQUIBB WHOLE ROOT RAUWOLFIA SERPENTINA

in anxiety and tension states . . .

stable ataractic (tranquilizing) effect
without excessive sedation

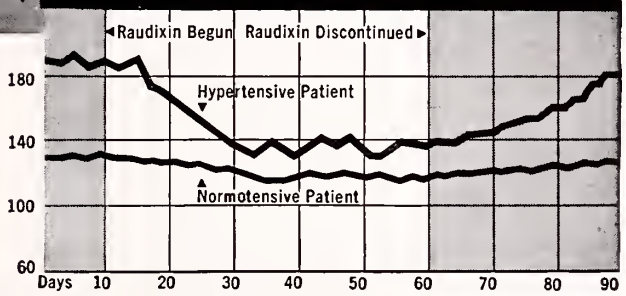
in hypertension . . .

stable hypotensive effect without rapid peaks and declines in blood pressure

DOSAGE: 100 mg. b.i.d. initially; may be adjusted within a range of 50 mg. to 500 mg. daily. Most patients can be adequately maintained on 100 mg. to 200 mg. daily.

SUPPLY: 50 mg. and 100 mg. tablets, bottles of 100, 1000 and 5000.

Comparative effect of Raudixin on the blood pressure of hypertensive patient and normotensive patient.



The hypotensive action of Raudixin is selective for the hypertensive state. For this reason, Raudixin does not significantly affect the blood pressure of normotensive patients.

SQUIBB

"RAUDIXIN"® IS A SQUIBB TRADEMARK

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

unique
in successfully fighting
malpractice charges

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

LOUISVILLE Office
Calvin Bimer, Representative
3119 Hewitt Ave.
Tel. Glendale 8-3060
If no answer, call Clay 3636

Foot-so-Port Shoe Construction and its Relation to Weight Distribution



- Insale extensian and wedge at inner carner af heel where suppart is mast needed.
- Special Supreme rubber heels are langer than mast anatamic heels and maintain the appearance af narmal shaes.
- The patented arch suppart canstructian is guaranteed nat ta break dawn.
- Innersales are guaranteed nat ta crack, curl, ar callapse. Insulated by a special layer af Texan which alsa cushians firmly and unifarmly.
- Faat-sa-Part lasts were designed and the shae canstructian engineered with arthapedic advice.
- NOW AVAILABLE! Men's conductive shoes. N.B.F.U. specifications. For surgeons and operating room personnel.
- By a special pracess, using plastic pasitive casts af feet, we make mare custam shaes far palia, club feet and all types af abnarmal feet than any ather manufacturer.

Write for detoils or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

WANTED

General Practitioner who can do some surgery, anaesthesia and obstetrics with a busy General Practitioner in Western Kentucky. Guarantee, and Commission Basis.

ADDRESS:
KSMA Box
620 South 3rd St.
Louisville, Ky.

RADIUM
(Including Radium Applicators)

For All Medical Purposes

Est. 1919

Quincy X-Ray & Radium Laboratories
(Owned and Directed by a Physician-Radialagist)

HAROLD SWANBERG, B.S., M.D., Director

W. C. U. Bldg. Quincy, Illinois

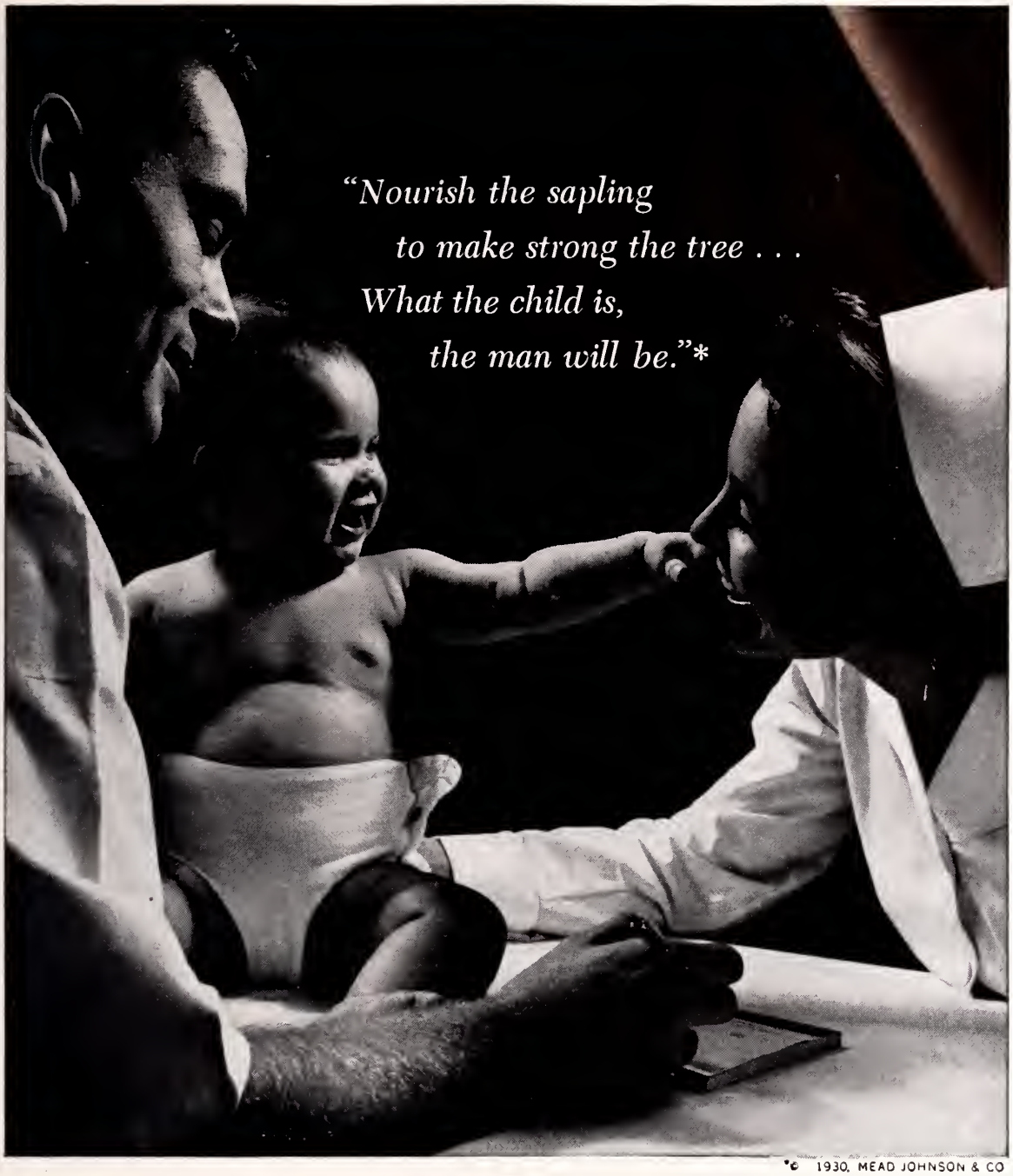
WAYSIDE HOSPITAL
168 North Broadway
Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

APPROVED BY AMERICAN MEDICAL ASSOCIATION

STAFF
H. HALBERT LEET, M.D. JOHN H. ROMPF, M.D.
CARL WIESEL, M.D. IRVING A. GAIL, M.D.
EDWARD L. HOUCHIN, ADMINISTRATOR

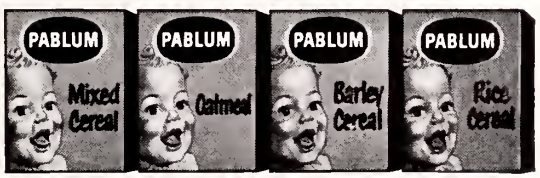
Phone: 2-2050



*© 1930, MEAD JOHNSON & CO

You can specify PABLUM *with confidence*

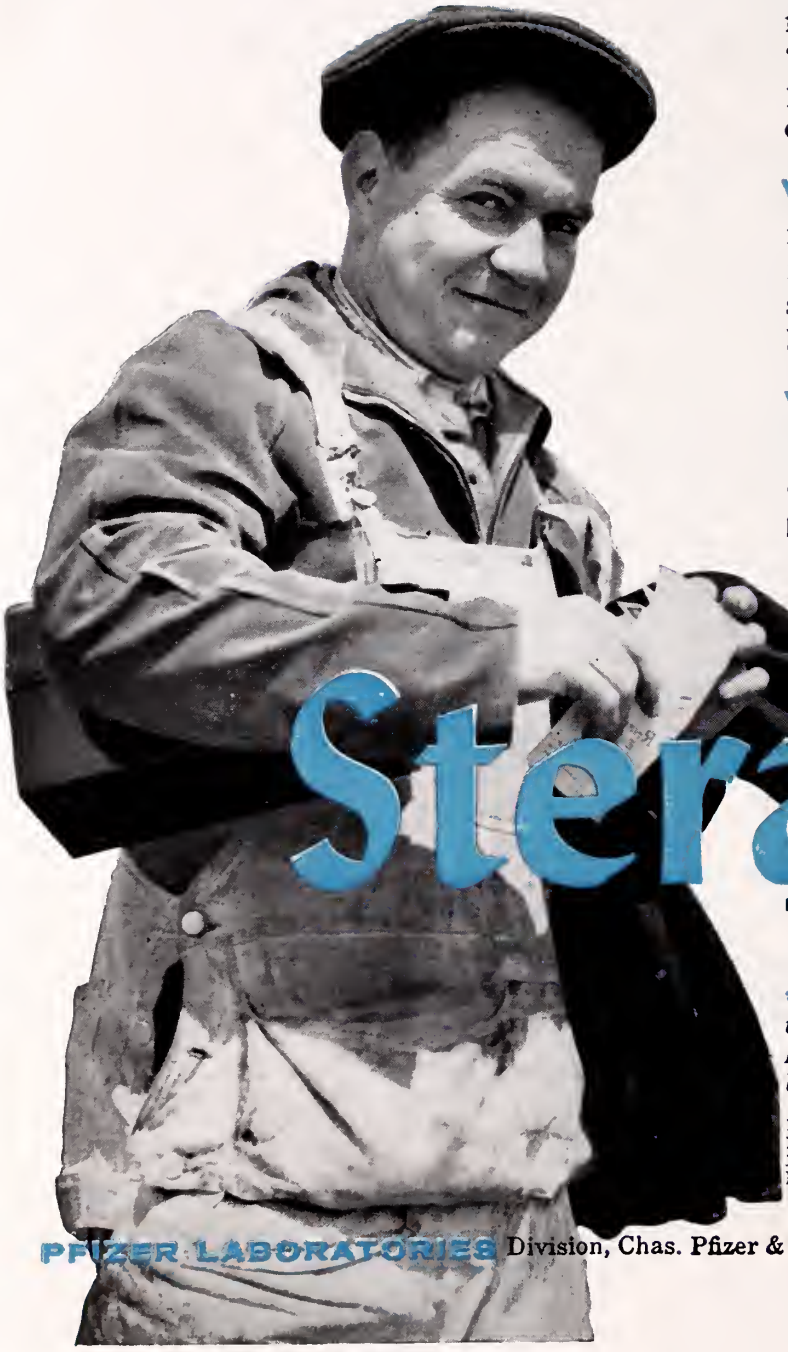
All physicians appreciate the strictness of pharmaceutical standards. Pablum Cereals are the *only* baby cereals made by nutritional and pharmaceutical *specialists.* All four Pablum Cereals are enriched with thiamine, riboflavin, calcium, phosphorus, copper, and with iron in its most assimilable form.



Now available in these bright new packages.

Pablum Products DIVISION OF MEAD JOHNSON & COMPANY, EVANSVILLE, IND. • Manufacturers of nutritional and pharmaceutical products

in rheumatoid arthritis



STANDING
is easier with STERANE[1]—3-5 times more potent than hydrocortisone or cortisone.[2]

WALKING
follows rapidly.[1] STERANE "is more effective than any previous drug in the control of...rheumatoid arthritis."[3]

WORKING
functional mobility is restored even where other steroids fail or cease to be effective.[2,3]

WITH MINIMAL DISTURBANCE
of electrolyte balance[1-3]—patients may even be treated without diet restrictions.

Sterane®
brand of prednisolone

supplied: *White, 5 mg. oral tablets, bottles of 20 and 100. Pink, 1 mg. oral tablets, bottles of 100.*

1. Spies, T. D., et al.: GP 12:73, No. 1, 1955. 2. Boland, E. W.: J.A.M.A. 160:613, 1956. 3. Gillhespy, R. O. Lancet 2:1393, 1955.

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

the most complete optical service in kentucky

Southern Optical COMPANY

HOME OWNED SINCE 1897

CONTACT LENSES
(Fluidless Lacrilens—Corneal)

ARTIFICIAL EYES
(Custom Plastic—Glass)

4th and Chestnut
334 W. Broadway
LOUISVILLE

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

Tax Returns
Bookkeeping
Delinquent Accounts
(No Commission)
Office Routines
Office Planning
Instructing Personnel
Fees
Partnerships
Hospitals
Clinics
Counselling - Investments
Insurance

Available

PROFESSIONAL BUSINESS MANAGEMENT

FOR DOCTORS ONLY

ASSOCIATES:

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hubert G. Stiffler
Daniel L. Zeiser
Richard J. Conklin

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945
WOodburn 1-1010

141 West McMillan Street
Cincinnati 19, Ohio

I would like to talk with one of your representatives

Name .....

Address .....

..... Telephone .....

All Services Completely Confidential

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)

(The Pioneer Postgraduate Medical Institution in America)

OBSTETRICS AND GYNECOLOGY

A two months full time course. In Obstetrics: lectures, prenatal clinics; attending normal and operative deliveries; detailed instruction in operative obstetrics (manikin). X-ray diagnosis in obstetrics and gynecology. Care of the newborn. In Gynecology: lectures; touch clinics; witnessing operations; examination of patients pre-operatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology. Culdoscopy. Studies in Sterility. Anesthesiology. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

SURGERY AND ALLIED SUBJECTS

A two months full time combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the words post-operatively. Pathology, radiology, physical medicine, anesthio. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver. Attendance at departmental and general conferences.

THE DEAN, 345 WEST 50th St., New York 19, N. Y.

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465
334 W. BROADWAY
LOUISVILLE, KENTUCKY

WAbash 6725

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**
( ) **Centralized Bookkeeping** (Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**

OCULISTS' PRESCRIPTIONS EXCLUSIVELY

MUTH OPTICAL COMPANY

Prescription Opticians

665 S. 4th **Brown Hotel Building** **Louisville 2**

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION — MEMBER AMERICAN HOSPITAL ASSOCIATION.

Clearview
On The Kratzville Road
EVANSVILLE, IND.

TELEPHONE 5-6181

A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.

SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery
ELECTROENCEPHALOGRAPH — CLINICAL LABORATORY—EKG AND BMR EQUIPMENT—STEREOSCOPIC X-RAY — HYDROTHERAPY.

ALBERT J. CREVELLO, M.D.
Diplomate, American Board of Psychiatry & Neurology, Inc.
MEDICAL DIRECTOR



THE MILTOWN MOLECULE

the tranquilizer with

NO KNOWN CONTRA-INDICATIONS

ideal for prolonged therapy

- Effective in anxiety, tension and muscle spasm
- Well tolerated—not habit forming—essentially non-toxic
- Does not produce depression
- Orally effective within 30 minutes for a period of 6 hours
- Supplied in 400 mg. tablets. Usual dose: 1 or 2 tablets—3 times a day

Miltown®

the original meprobamate—2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720

DISCOVERED AND INTRODUCED by Wallace Laboratories, New Brunswick, N. J.

Literature and Samples Available on Request

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS—1955-56

Gant Gaither, 109½ East 7th Street, Hopkinsville ..... President
Richard R. Slucher, Buechel ..... President-Elect
Clyde C. Sparks, M.D., Mayo Arcade Ashland ..... Immediate Past President
Everett Baker, 408 Brown Bldg., Louisville ..... Vice-President
N. Lewis Bosworth, M.D., 1701 Fincastle Rd., Lexington ..... Vice-President
Howell J. Davis, 330½ Allen, Owensboro ..... Vice-President
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Secretary-Editor Pro tem
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Treasurer
Charles A. Vance, 271 W. Short Street, Lexington ..... Speaker—House of Delegates
E. W. Jackson, 333 Broadway, Paducah ..... Vice Speaker—House of Delegates
J. Vernon Pace, 709-10 Citizen's Bank Bldg., Paducah ..... Chairman of the Council
Delmas M. Clardy, Hopkinsville ..... Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan	1956
Alternate to be Appointed	1956
W. Vinson Pierce, 33 E. Seventh St., Covington	1957
Leon Higdon, 333 Broadway, Paducah, (Alternate)	1957

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Building, Paducah	1956
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1958
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Carlisle Morse, 3612 Lexington Road, Louisville	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1958
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1957
Ninth District	J. M. Stevenson, Brookville	1958
Tenth District	J. Farra Van Meter, 183 N. Upper Street, Lexington	1958
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1958
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Charles B. Stacy, Pineville	1957

BUYERS GUIDE

JOURNAL OF THE KENTUCKY STATE MEDICAL ASSOCIATION, MAY, 1956

American Meat Institute 390
Ames Company, Inc., ... 471
Ayerst Laboratories 455
Bayer Co. (Division of Sterling Bayer) 395
Brayten Pharmaceutical Co., ... 403
Brown & Williamson Tobacco Co., ... 408
Burroughs Welcome & Company 400
Ciba Pharmaceutical Company 451
Cincinnati Sanitarium 470
City View Sanitarium 456
Clearview Sanitarium 466
The Coca-Cola Company 469
Crocker-Fels Company 450
Fairmount Hospital 469
Foot-So-Port Shoe Co., ... 462
Chas. B. Knox Gelatine Co., ... 406
The Keeley Institute 466
K.S.M.A. (Want ad) 462
Lakeside Laboratories 407, 456, 469
Lederle Laboratories 428, 429
Eli Lilly & Co., ... 410
W. R. Long (Ins. Co.) 398
Louisville Med. Dental Business Bureau 466
Mead Johnson & Company 463
Medical Protective Company 462
Muth Optical Company 466
New Castle Sanitarium 456
N. Y. Polyclinic Med. Sch. & Hasp. 466
Parke, Davis & Company 386, 387, 458, 459
Pfizer Laboratories 399, 464
Physicians Casualty Ins. Co., ... 454
Pleasant Grove Hospital 452
Quincy X-Ray & Radium Laboratories 462
Schering Corporation 394, 401, 409
Schering Corporation ..... Insert
Scientific Exhibit 430
Clayton L. Scroggins & Associates 465
G. D. Searle & Company 447
Sharpe & Dohme 389, 397, 404, 405, 453
Smith, Kline & French 472
Southern Optical Company 465
R. E. Squibb & Company 461
The Training School of Vineland, N. J. 469
Upjohn Company 393, 448
Wallace Laboratories 467
Wayside Hospital 462
White Cross Hospital 460
Winthrop Laboratories 457
Wyeth, Incorporated 391, 449

Relax the best way ... pause for Coke



continuous quality is quality you trust

DRINK Coca-Cola
REG. U.S. PAT. OFF.

SECLUSION MATERNITY



FAIRMOUNT HOSPITAL
FOR UNMARRIED GIRLS
Est. 1909

Private sanitarium with certified obstetrician in charge. Folder fully describing services FREE on request. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

Write for Information
MRS. HELEN AMOS
4911 East 27th St.
Kansas City, Mo.
Phone: WA. 3-3577

The TRAINING SCHOOL at VINELAND, NEW JERSEY

For Retarded and Slow-Learning Children.

Established in 1888 as the "Village of Happiness"; for boys and girls, all ages. Academic, vocational, social training; wide recreation; cottage living; medical, psychiatric, psychologic services. Year-round program. Special Summer Program. Internationally known research center.

Write Director, **The Training School at Vineland, New Jersey. Phone 7-0021**

"...WHEN CONTINUOUS DIURESIS IS MANDATORY TO CONTROL HEART FAILURE, NEOHYDRIN BECOMES THE SUPERIOR [ORAL] AGENT, SINCE THIS COMPOUND CONTINUES TO PRODUCE DIURESIS WHEN ADMINISTERED DAILY"*

*Moyer, J. H., and Hughes, W. M.: J. Chron. Dis. 2:678, 1955.

00656

THE CINCINNATI SANITARIUM

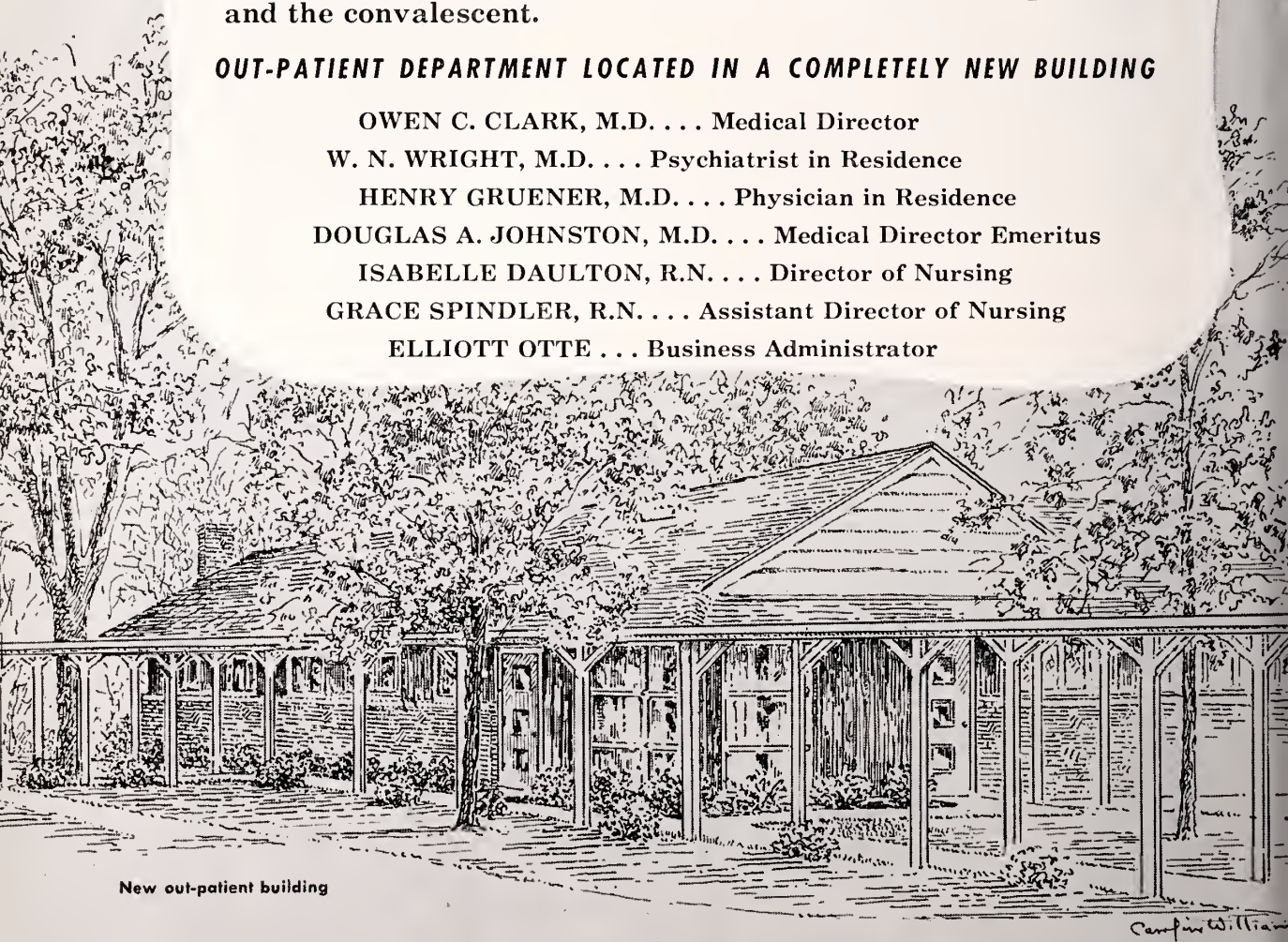
ESTABLISHED 1873

A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
- Ample classification facilities with qualified psychiatric nursing.
- Complete occupational therapy and recreation activities.
- Rest Cottage, a separate department for mild neurotic problems and the convalescent.

OUT-PATIENT DEPARTMENT LOCATED IN A COMPLETELY NEW BUILDING

OWEN C. CLARK, M.D. . . . Medical Director
W. N. WRIGHT, M.D. . . . Psychiatrist in Residence
HENRY GRUENER, M.D. . . . Physician in Residence
DOUGLAS A. JOHNSTON, M.D. . . . Medical Director Emeritus
ISABELLE DAULTON, R.N. . . . Director of Nursing
GRACE SPINDLER, R.N. . . . Assistant Director of Nursing
ELLIOTT OTTE . . . Business Administrator



New out-patient building

write for descriptive booklet

THE CINCINNATI SANITARIUM

5642 HAMILTON AVENUE, Cincinnati 24, Ohio

Telephone KIrby 1-0135 KIrby 1-0136

NEW CONCEPT IN URINE-SUGAR TESTING

CLINISTIX

TRADEMARK

REAGENT STRIPS

specific enzyme test for urine glucose



just dip and read



complete specificity ... unaffected by non-glucose reducing substances ... differentiates glucose from other urine-sugars ... thousands of tests reveal no substance causing a false positive.

extreme sensitivity ... detects glucose concentrations of 0.1% or less.

utmost simplicity and convenience ... a CLINISTIX Reagent Strip moistened with urine turns blue when glucose is present.

qualitative accuracy ... used whenever presence or absence of glucose must be determined rapidly and frequently. CLINISTIX does not attempt to give quantitative results because so many factors in urine influence enzyme reactions.

economy ... CLINISTIX saves time and cuts costs ... each strip is a complete test rapidly performed without reagents and equipment.

available: Packets of 30 CLINISTIX Reagent Strips in cartons of 12—No. 2830.

AMES COMPANY, INC • ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

13356

to help you relieve

the severe emotional upset

of the menopausal patient



THORAZINE*

'Thorazine' can facilitate the over-all management of your menopausal patient. Its unique, non-hypnotic tranquilizing effect relieves anxiety, tension, agitated depression and helps you to restore to the patient a feeling of well-being and a sense of belonging.

'Thorazine' is available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

For information write:

Smith, Kline & French Laboratories, Philadelphia 1

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



In this issue:

A Case of Conversion Hysteria
What Americans Think of Doctors
Oral Treatment of Diabetes Mellitus

See table of content page 476

KSMA
Annual Meeting
Sept. 18-20, 1956

VOLUME 54 • NUMBER 6 • JUNE 1956



help assure optimal nutrition
during gestation...
throughout lactation

NATABEC® KAPSEALS®

vitamin-mineral combination

You can help assure optimal nutrition in your patients during pregnancy and lactation by supplementing their diet with NATABEC Kapseals. Designed to improve intake of important vitamins and minerals at these times of increased nutritional need, NATABEC Kapseals, taken regularly, help avoid complications and aid in safeguarding the health of both mother and child.

dosage: As a dietary supplement during pregnancy and lactation, one or more Kapseals daily. NATABEC Kapseals are available in bottles of 100 and 1,000.

Each NATABEC KAPSEAL represents:

Calcium carbonate	600 mg.	Synkamin (vitamin K as the hydrochloride)	0.5 mg.
Ferrous sulfate	150 mg.	Rutin	10 mg.
Vitamin B_{12} (crystalline)	2 mcg.	Vitamin B_2 (riboflavin)	2 mg.
Folic acid	1 mg.	Nicotinamide (niacinamide)	10 mg.
Vitamin A	4,000 units	Vitamin B_6 (pyridoxine hydrochloride)	1 mg.
Vitamin D	400 units	Vitamin C (ascorbic acid)	50 mg.
Vitamine B_1 (thiamine hydrochloride)	3 mg.		

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

50062

The JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR PRO TEM: W. B. TROUTMAN, M. D. MED. EDITORIAL EDITOR: S. A. OVERSTREET, M. D.
MANAGING EDITOR: J. P. SANFORD BOOK REVIEW EDITOR: WALTER S. COE, M. D.
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D. ORGANIZATION EDITOR: BARBARA N. MORGAN
CASE DISCUSSIONS EDITOR: J. C. BELL, M. D. PRINTERS: GIBBS-INMAN, LOUISVILLE

ADVISORY COMMITTEE TO THE EDITOR

Richard J. Rust, M. D. Guy Aud, M. D., Chairman James E. Hix, M. D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1958	Term Expires July 1, 1957	Term Expires July 1, 1956
Henry B. Asman, M.D.	Carey C. Barrett, M.D.	Everett H. Baker, M.D.
Richard Elliott, M.D.	Joe Bush, M.D.	John L. Dixon, M.D.
Rankin Blount, M.D.	Allen E. Grimes, M.D.	George G. Greene, M.D.
Marion F. Beard, M.D.	Richard F. Grise, M.D.	R. Arnold Griswold, M.D.
Glenn Bryant, M.D.	Billy Keller, M.D.	O. Leon Higdon, M. D.
Douglas Scott, M.D.	A. J. Miller, M.D.	James M. Keeton, M.D.
William C. Buschemeyer, M.D.	Robert Reeves, M.D.	Frank Moore, M.D.
Harry D. Abell, M.D.	Charles R. Yancey, M.D.	Alvin C. Poweleit, M.D.

Published at 620 S. Third Street, Louisville 2, Kentucky

Subscription $8.00 per year Single Copy .80

Contents

SCIENTIFIC ARTICLES

INTESTINAL OBSTRUCTION FROM RADIOLOGICAL POINT OF VIEW, Everett Pirkey, M.D., and Dale Undem, M.D. 499

PROLAPSE OF FALLOPIAN TUBE AFTER VAGINAL HYSTERECTOMY-REPORT OF THREE CASES, W. O. Johnson, M.D. 505

THE CURRENT STATUS OF BILIARY SURGERY, Hart Hagan, M.D., and William Hagan, M.D. 507

PHEOCHROMOCYTOMA, Russell A. Del Toro, M.D., ... 512

VIRUS DISEASES AND VACCINES, Wilfrid C. Gettelfinger, M.D. 521

TREATMENT OF CHRONIC VENOUS INSUFFICIENCY, Bert Seligman, M.D., ... 524

CASE DISCUSSION 528

STATE HOSPITAL AND DISCHARGE PROCEDURES 530

EDITORIALS

WHAT DO AMERICANS THINK OF THE MEDICAL PROFESSION? 531

ORAL TREATMENT OF DIABETES MELLITUS 532

ORGANIZATION SECTION

Annual Meeting Speakers Announced....533

'56 KSMA Meeting Program Listed.....533

'53 GP of the Year Dies May 8.....534

6th District Session is June 27.....534

12th-15th Districts Plan Meeting 535

MDs Invited to Kenlake Seminar 535

240 Attend Fayette Meeting 535

Dr. Fortune Speaks at Charleston 535

Dr. Massie Heads Surgical Society 536

Dr. Griswold is ACS President 536

Eighth, Ninth Districts Meet 537

Four Districts Have April Meetings 537

REGULAR DEPARTMENTS

President's Page 480, In the Books, 484, Washington News Digest 490, News Items 542, In Memoriams 544

Second Class Mail privileges authorized at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

your patient should not be endangered by fluid accumulation during "rest periods"

YOUR PATIENT NEEDS AN ORGANOMERCURIAL

When a diuretic must evoke acidosis to be effective, continued administration without dosage limitation results in refractoriness. Other diuretics may require interrupted dosage to avoid gastro-intestinal irritation.

But the sustained diuresis achieved by the organomercurials never necessitates routine "rest periods" because of their mode of action.

TABLET NEOHYDRIN®

BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure MERCUHYDRIN® SODIUM
BRAND OF MERALLURIDE INJECTION

01256

LAKESIDE

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

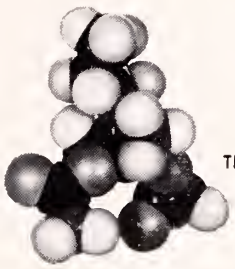
POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.



THE MILTOWN MOLECULE

A tranquilizer well suited for prolonged therapy

NO ORGANIC CONTRAINDICATIONS

reported to date

- well tolerated, non-addictive, essentially non-toxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

Indications: anxiety and tension states, muscle spasm.

Miltown®

the original meprobamate—2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720

SUPPLIED: 400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.

DISCOVERED AND INTRODUCED by Wallace Laboratories, New Brunswick, N. J.
Literature and Samples Available on Request

message from the President

From time to time articles appear in our professional literature regarding the handling of mass casualties. Most of us ignore them or read them with only a passing interest.

A recent plane crash has brought the need for such planning into a sharp focus in our community. The presence of industrial plants, trains, busses, planes, auditoriums, movies, etc. make such planning imperative any place in our state. The knowledge that outlying communities will be forced to care for the casualties of target areas in case of atomic attack further adds to the necessity for such planning.

Our inability to stockpile needed supplies and equipment should not stop us from having a well organized plan for the handling of a large number of casualties.

It so happened that the 30 odd casualties did not materialize but I am extremely proud of the manner in which our hospitals responded with shock teams—nurse help, mobilization of supplies and equipment. Our sheriff's office, police department, fire department, even the local National Guard unit worked smoothly to care for the casualties and the wreck itself.

Howell J. Davis, M.D.
Vice-president

clinically proved in many common infections[1-60]

Hemolytic streptococcal infections

Pharyngitis/Tonsillitis/Sinusitis
Otitis media/Mastoiditis
Scarlet fever/Lymphadenitis/Erysipelas

Staphylococcal infections/Pneumococcal infections/Gonococcal infections/ Vincent's Infection/Prevention of streptococcal infection in individuals with a history of rheumatic fever/ Prevention of secondary infection due to penicillin-susceptible organisms

in dosage of just 1 or 2 tablets t.i.d.

and is far less costly than other penicillin salts

Pentids

SQUIBB 200,000 UNIT BUFFERED PENICILLIN G POTASSIUM TABLETS

Recommended dosage: 1 or 2 tablets t.i.d. without regard to meals. Bottles of 12 and 100.

References: 1. Boger, W. P., J. Amer. Ger. Soc. 3:556, Aug. 1955. 2. Lapin, J. H., Ann. Allergy 13:169, March-April 1955. 3. Andelman, M. B. and Fischbein, W. I., Antibiotic Med. 1: 136, March 1955. 4. Statements of American Heart Association, Council on Rheumatic Fever and Congenital Heart Disease, Circulation 11:317, Feb. 1955. 5. Miller, J. M. et al., Antibiotics Annual 1954-55, Medical Encyclopedia Inc., N. Y., p. 105. 6. Seal, J. R. et al., J. Lab. & Clin. Med. 44:831, Dec. 1954. 7. Martin, W. J. et al., Am. Pract. & Dig. Treat. 5:813, Oct. 1954. 8. Henner, R., Eye, Ear, Nose & Throat Monthly 33:530, Sept. 1954. 9. Rodstein, M. and Young, D., Clin. Med. 61:695, Sept. 1954. 10. Bernstein, S. H. et al., A. M. A. Arch. Int. Med. 93:894, June 1954. 11. Craige, E., North Carolina M. J. 14:593, Dec. 1953. 12. Barach, A. L., J. Amer. Ger. Soc. 1:616, Sept. 1953. 13. Barach, A. L., Geriatrics 8:423, Aug. 1953. 14. Boger, W. P., Indus. Med. & Surg. 22:288, July 1953. 15. Young, D. and Rodstein, M., J.A.M.A. 152:987, July 1953. 16. Queries and Minor Notes, J.A.M.A. 152:1083, July 1953. 17. Roberts, E., A. M. A. Amer. J. Dis. Child. 85: 643, June 1953. 18. Spink, W. W., J.A.M.A. 152:585, June 1953. 19. Huang, N. N. and High, R. H., J. Pediat. 42:532, May 1953. 20. Antibiotics: Round Table Discussion, Pediatrics 11:270, March 1953. 21. Feinberg, B., Rhode Island M. J. 36: 138, March 1953. 22. Flippin, H. F., Delaware State M. J. 25: 55, March 1953. 23. Denny, F. W. Jr., Postgrad. Med. 13:153, Feb. 1953. 24. Flood, J. M., A. M. A. Arch. Dermat. & Syph. 67:42, Jan. 1953. 25. Kohn, K. H., Milzer, A. and MacLean, H., J.A.M.A. 151:347, Jan. 1953. 26. Siegal, S. et al., J. Allergy 24:1, Jan. 1953. 27. Statements of American Heart Association, Council on Rheumatic Fever and Congenital Heart Disease, J.A.M.A. 151:141, Jan. 1953. 28. Keefer, C. S., Pennsylvania M. J. 55:1177, Dec. 1952. 29. Kerrell, W. E., J.A.M.A. 150:1450, Dec. 1952. 30. Levy, D. F., Connecticut State M. J. 16:899, Dec. 1952. 31. Romansky, M. J. and Kelser, G. A., J.A.M.A. 150:1447, Dec. 1952. 32. Thomas L., Minnesota Med. 35:1105, Dec. 1952. 33. Jones, C. C., J. Iowa M. Soc. 42:533, Nov. 1952. 34. Reimann, H. A., Postgrad. Med. 12:255, Sept. 1952. 35. Bunn, P. A., N. Y. State J. Med. 52:2005, Aug. 1952. 36. Finland, M., New England J. Med. 247:557, Oct. 1952. 37. Babione, R. W. et al., U. S. Armed Forces M. J. 3:973, July 1952. 38. Hansen, A. E., South. M. J. 45:423, May 1952. 39. Dowling, H. F., G. P. 5:53, Feb. 1952. 40. Rhoades, P. S., G. P. 5:67, Feb. 1952. 41. Dowling, H. F. and Lepper, M. H., Med. Clin. North Amer., Jan. 1952, p. 247. 42. Karelitz, S. and Schifrin, N., Postgrad. Med. 11:17, Jan. 1952. 43. Panel Discussion, Pennsylvania M. J. 55:42, Jan. 1952. 44. Flippin, H. F. et al., J.A.M.A. 147:918, Nov. 1951. 45. Massell, B. F., Mod. Concepts Cardiovas. Dis. 20:105, Sept. 1951. 46. Weinstein, L., Boston Med. Quarterly 2:1, Sept. 1951. 47. Massell, B. F. et al., J.A.M.A. 146:1469, Aug. 1951. 48. Finland, M., Bull. New York Acad. Med., 27:199, April 1951. 49. Wheatley, D., Brit. M. J. 1:703, March 1951. 50. Keefer, C. S., Postgrad. Med. 9:101, Feb. 1951. 51. Bunn, P. A. et al., J.A.M.A. 144: 1540, Dec. 1950. 52. Weinstein, L. and Perrin, T. S., J. Pediat. 47:844, Dec. 1950. 53. Keefer, C. S., Am. J. Med. 7:216, Aug. 1949. 54. Robinson, J. A., Hirsch, H. L. and Dowling, H. F., Am. J. Med. 4:716, 1948. 55. Barach, A. L. and Garthwaite, B., Ann. Allergy 5:297, Aug. 1947. 56. Herrold, R. D., J. Urol. 57:897, May 1947. 57. White, H. J., Lee, M. E. and Alverson, C., Proc. Soc. Exper. Biol. & Med. 62:35, 1946. 58. Baumann, F. et al., J. Allergy 17:264, Sept. 1946. 59. Gamble, T. O. et al., Am. J. Obst. & Gynec. 50:514, Nov. 1945. 60. Woofter, A. C. and Hoffman, O. E., J. Iowa M. Soc. 35:189, May 1945.

'PENTIDS'® IS A SQUIBB TRADEMARK

SQUIBB Squibb Quality—the Priceless Ingredient



KARO® SYRUP...meets all the criteria for effective milk modification

Because Karo Syrup is a balanced fluid mixture of dextrins, maltose, and dextrose, it is well tolerated, easily digested and completely utilized. Its use will not induce flatulence, colic, fermentation or allergy.

Obviously, the selection of a milk modifier for infant feeding depends to a large extent upon the needs of the individual infant. But, after three generations of use, Karo is still a carbohydrate modifier of choice for *all* infants.

From the standpoint of the physician, Karo permits easy adjustment of formula and safe transition from liquid to solid food as circumstances demand.

Mothers appreciate the fact that Karo is readily available, inexpensive and easy to use.

Light or dark Karo Syrup may be used interchangeably, with cow's milk or evaporated milk and water. Each tablespoonful yields 60 calories.



1906 • **50th ANNIVERSARY** • 1956
CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N.Y.

THIS IS HOW

Rauwiloid®

The original alseroxylon fraction of India-grown Rauwolfia serpentina, Benth.

Differs

from all other Rauwolfia preparations

Higher Clinical Efficacy

Rauwiloid represents the balanced, mutually potentiated actions[1] of several Rauwolfia alkaloids, of which reserpine and the equally antihypertensive rescinnamine have been isolated. Hence, contrary to reports from some quarters, reserpine is not the only active principle of the Rauwolfia plant. Rauwiloid contains *all* the active principles, but it is freed of the undesirable dross of the crude Rauwolfia root.

Greater Safety

No single commercially available alkaloid can provide the full efficacy of Rauwiloid together with Rauwiloid's low incidence/low intensity of side actions.[2] For example, mental depression is "much less frequent with alseroxylon..."[2] Rauwiloid is safely used even in the presence of cardiac, renal, and cerebrovascular complications of hypertension.

Antihypertensive

Bradycrotic

Tranquilizing

Simplified Dosage

Dosage is simple...merely two 2 mg. tablets at bedtime. When desired effect has been obtained, one tablet per day often suffices.

1. Cronheim, G., and Toekes, I. M.: Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

Riker

LOS ANGELES



OFFICE PROCEDURES: by Paul Williamson, M.D.: published by W. B. Saunders Company on August 18, 1955: 412 pages: $12.50

This book is a valuable contribution to the busy generalist's library. The most frequently used office procedures are described in simple terms and easily understood illustrations are profusely and advantageously employed. The organization is excellent. There are 16 major divisions and a complete index. At the beginning of each major section the author has augmented the usability of his publication by carefully subdividing the ensuing chapter.

Dr. Williamson has combined his own experience with that of many other physicians and has produced in one volume a guide to the commonly used mechanics of office work. He has also demonstrated his ingenuity in making useful instruments from generally available articles such as paper clips and hairpins.

Most of us will profit from the frequent use of this manual. It is strongly recommended to the young man who is just starting his practice. He will find here a means whereby he can quickly evolve proper approaches to the countless minor office problems which confront all general practitioners.

G. J. Sweeney, M. D.

EXPERIMENTAL TUBERCULOSIS — BACILLUS AND HOST: Editors for the Ciba Foundation—G. E. W. Wolstenholme, OBE, MA, MB, Bch and Margaret P. Cameron, MA, ABLS and assisted by Cecilia M. O'Conner, BSc: Little Brown and Company: 396 pages: $9.00.

It has been 74 years since Koch discovered the tubercle bacillus, and still the search goes on to unravel the intricacies of this unique organism.

Fishberg remarked years ago that the evolution of tuberculosis was perhaps more dependent on the "soil" than on the bacillus itself. The implication being, if one could change the tissues of the host so as to present an unfavorable environment for the tubercle bacillus we would be well on our way to conquering this disease. It is well known that tubercle bacilli are destroyed in the resistant host, even without treatment.

The article by Hirsch, "Biochemical factors which may influence the fate of tubercle bacilli in tissues," indicates that spermine is one of these substances which occurs normally in many tissues in a concentration greater than that which kills tubercle bacilli under certain conditions "in vitro."

For those addicted to the indiscriminate use of Cortisone without first interrogating the chest, Laurie's experiment shows that Cortisone alters the hormone balance and deprives the phagocytes of their inate capacity to inhibit the growth and multiplication of tubercle bacilli in their cytoplasm, even though their phagocytic activity is not impaired.

The research worker in tuberculosis is naturally thoroughly familiar with the literature in his own field; to him therefore the book will be of little value, except as a ready reference. To the clinician and student of tuberculosis much information is compressed in the 387 pages which is capable of broadening their concept of this protean disease.

Oscar O. Miller, M. D.

CARDIAC DIAGNOSIS — A PHYSIOLOGIC APPROACH: by Robert F. Rushmer, M.D.: published by W. B. Saunders Company: 447 pages: $11.50:

Any doubt that we are in a physiologic era as regards the diagnosis of heart disease is dispelled by this book. It "represents an approach to cardiac diagnosis based on the function and control of the heart under normal and abnormal conditions." Current principles are well presented, aided by excellent schematic illustrations. Graphs and tables are avoided. Presentations of conflicting viewpoints are also avoided. The author admits that this might make him appear to be excessively biased. But in this field of endeavor in which there is tremendous current investigation, (the journal "Circulation Research" was recently established) who is to decide what hypothesis is the right explanation for a particular phenomenon?

Dr. Rushmer has not written a text book on heart disease. Less than a third of the book is devoted to the application of physiological principles to cardiac diagnosis, and then only five main etiologic types are considered—including "possible heart disease." The wide gap between the application of physiological principles to the diagnosis of heart disease as arrived at in the physician's office, is well illustrated in the final chapter on "Possible Heart Disease." An adequate history, the basic principles of palpation, percussion and auscultation, determination of the arterial blood pressure by a cuff, combined with roentgenography and electrocardiography are alone discussed. To this could be added a determination of the circulation time and venous blood pressure.

Such procedures as the determination of the intra-arterial blood pressure, catheterization of the right and left sides of the heart, angiocardiography, varied methods for the determination of cardiac output and even ballistocardiography and spatial vectrocardiography are still either impractical or are too experimental to be used as part of an office examination.

This is an excellent book for a medical student or the "working cardiologist." It should interest the internist. It is not recommended to the general practitioner.

Morris M. Weiss, M. D.



BON VOYAGE BEGINS WITH BONAMINE*

BRAND OF MECLIZINE HYDROCHLORIDE HCl

longest-acting motion-sickness remedy[1] effective in low dosage . . . controls motion sensitivity symptoms in minutes . . . one dose usually prevents motion sickness for 24 hours.

in recommended dosage Bonamine is notably free from side reactions . . . supplied as: BONAMINE TABLETS, scored, tasteless, 25 mg. . . . BONAMINE CHEWING TABLETS, pleasantly mint flavored, 25 mg.

*Trademark 1. Report of Study by Army, Navy, Air Force Motion Sickness Team: J.A.M.A. 160:755 (March 3) 1956.

Pfizer PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.

Plan Now

to attend the

1956 KSMA ANNUAL MEETING

Columbia Auditorium
Louisville

Sept. 18-19-20

- 12 nationally known guest speakers
- three six hour refresher courses
- carefully selected scientific movies
- outstanding scientific exhibits
- 64 technical exhibits
- other top features

SOCIALIZED MEDICINE

May never come, but . . . Socialized Insurance is here to stay, and it has created a sizable Estate Handicap against the physician.

In the case of a young doctor with young children, this economic penalty may be as high as $40,000.00

But there is a solution, and the cost is no greater than the Social Security Tax. Write now for complete information

---

W. R. LONG & ASSOCIATES
1534 Bardstown Road—Louisville, Ky.

Without obligaiton to me I would like to have more information about the solution to the Social Security problem of the young doctor. I am in good health and was

born .....
Month Day Year

Name .....

Address .....

The **NEW** Phenothiazine Derivative

Sparine*

Promazine Hydrochloride

10-(γ-dimethylamino-*n*-propyl)-phenothiazine hydrochloride

For the Management of the Acutely Agitated Patient

• ***The acute alcoholic*** • ***The acute psychotic*** • ***The drug addict***

A promising new agent in chemopsychotherapeutics, **SPARINE** has demonstrated impressive effectiveness in controlling acute excitation without inducing significant side-reactions.[1,2,3]

SPARINE is a new, clinically effective phenothiazine derivative, which may be administered intravenously, intramuscularly, or orally. The route and dosage are determined by the extent of central-nervous-system excitation and by the patient's response.

Supplied: Tablets, 25, 50, and 100 mg., bottles of 50 and 500; 200 mg., bottles of 500. Injection, 50 mg. per cc., vials of 2 and 10 cc.

1. Seifter, J., et al.: To be published. 2. Fazekas, J.F., et al.: M. Ann. District of Columbia 25:67 (Feb.) 1956. 3. Mitchell, E.H.: J.A.M.A. In press.

Wyeth®
Philadelphia 1, Pa.

*Trademark

An Exclusive Development of Wyeth Research

Relax the best way ... pause for Coke



continuous quality
is quality you trust

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of
mental and nervous disorders, and
addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director

Upjohn
KALAMAZOO

Indicated in most conditions in which oral cortisone or hydrocortisone is effective. Available in 2.5 mg. tablets in bottles of 100, and in 5 mg. tablets in bottles of 30, 100, and 500. Usual dosage is ½ to 1 tablet three or four times daily

Deltasone*

Less sodium retention less potassium depletion

*Trademark for the Upjohn brand of prednisone (delta-1-cortisone)

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

Tax Returns
Bookkeeping
Delinquent Accounts
(No Commission)
Office Routines
Office Planning
Instructing Personnel
Fees
Partnerships
Hospitals
Clinics
Counselling - Investments
Insurance

ASSOCIATES:

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hubert G. Stiffler
Daniel L. Zeiser
Richard J. Conklin

Available

PROFESSIONAL BUSINESS MANAGEMENT

FOR DOCTORS ONLY

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945
WOodburn 1-1010

141 West McMillan Street
Cincinnati 19, Ohio

I would like to talk with one of your representatives

Name .....

Address .....

..... Telephone .....

All Services Completely Confidential



WASHINGTON NEWS DIGEST



Washington, D. C.—As might be expected, a presidential commission's report on veterans' pensions that also goes into the subject of non-service connected medical benefits is stirring up another controversy.

The President's Commission on Veterans' Pensions, headed by Gen. Omar Bradley, World War II leader and postwar Veterans' Administrator, conducted a study covering more than a year in time and a wide range of subjects. It produced a 415-page report and a total of 70 recommendations.

The seven-man commission's report has this basic premise: military service in time of war or peace should be treated as discharging an obligation of citizenship and not of itself as a basis for future government benefits.

The commission made this additional point: ". . . under conditions of modern technology and warfare, the national defense might be served equally well by a civilian in a scientific laboratory or a war plant as by a uniformed serviceman—and in view of total war and atomic weapons, perhaps with greater personal hazard to the civilian. This further suggests that the special needs that veterans have because of military service should not be confused with the needs that all citizens have in common for such things as education, health services and economic security."

With this in mind, the commission proposes the gradual elimination of non-service connected benefits and observes: "Their justification is weak and their basic philosophy is backward looking rather than constructive." Such benefits, it adds, should be limited to a minimum level and retained only as a reserve line for veterans who fail to qualify for basic protection under Old Age and Survivors Insurance (Social Security.)

The commission then goes one step further by recommending an end to the present automatic "presumption of service-connection" procedure. Now, presumption of service connection is automatic and mandatory for certain diseases if the condition is diagnosed within a specific period of time following discharge. Instead, the commission would substitute medical determination for chronic and tropical diseases, psychoses, tuberculosis and multiple sclerosis, with each case decided on its own merits.

Other recommendations: (1) increased reliance on the OASI system for certain veterans benefits, (2) prompt counseling of all veterans placed on compensation rolls as to VA and federal-state rehabilitation programs, and (3) requirement of reasonable medical or surgical treatment before payment of compensation.

Representatives of veterans groups called before the House Veterans Affairs Committee to comment on the study complained that some of its proposals would be "extremely destructive" to certain aspects of veterans compensation.

NOTES:

Two committees of Congress, after long studies of problems of narcotics, barbiturate and amphetamine addiction, have come up with recommendations that the U. S. tighten penalties on narcotics peddling and smuggling, outlaw heroin and set up a central unit in the Federal Bureau of Narcotics to keep track of known addicts. The proposals were made by the Senate Judiciary committee and a House Ways and Means subcommittee.

The House committee also suggested a law for more stringent controls over barbiturates and amphetamines.

The Senate committee rejected the proposal backed by the New York Academy of Medicine for "clinics" where known addicts could go for regular doses of narcotics.

* * *

U. S. Public Health Service is advising private physicians as well as health officers to increase their use of Salk poliomyelitis vaccine. Although supplies now lag behind demand, the expectation is that before the summer is out the situation will be reversed. In line with this recommendation, PHS is urging that physicians use what supplies they have on hand immediately, depending on future production to take care of second and third shots.

* * *

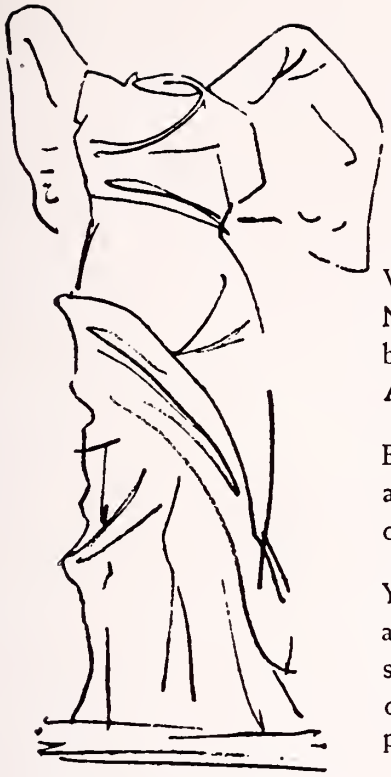
Because the President signed the military career incentive bill promptly, physicians in uniform received their pay raises starting May 1. The minimum boost (after two years' service) is $50 per month, the maximum (after 10 years) $150.

* * *

Private-profit nursing homes, hospitals and some other medical facilities soon will have an opportunity to obtain U. S. loans from the Small Business Administration. The limit is $250,000 per project, the interest rate usually six per cent.

* * *

If there was any question about it, the AFL-CIO as a joint organization favors national compulsory health insurance, as each group did before the merger. The AFL-CIO stand was taken officially for the unions by Nelson Cruikshank in testimony before the House Ways and Means Committee on a bill for increased payments for the medical care of public relief recipients.



Lasker Award statuette



an acknowledgment

We are proud that our television series on the NBC network, "The March of Medicine", has been selected to receive the first Albert Lasker Award in the field of television and radio.

But we feel that those really being honored are you—the physicians and research scientists of America.

Your sense of responsibility to the public—and that of your hospitals, laboratories, and staffs—has made it possible for "The March of Medicine" to report the story of medical progress.

The Lasker Awards heretofore have been bestowed on many of the nation's outstanding medical scientists and journalists. As a member of the pharmaceutical industry, we are particularly grateful for the honor represented by this award.

We are also grateful for the support we have continually received from the American Medical Association, which has cooperated in this series from the very beginning.

Francis Boyer

Francis Boyer
President
Smith, Kline & French Laboratories



SEEKING A TIME-SAVING INFANT FOOD

BAKER'S MODIFIED MILK*

Designed for all infant feeding from birth to the end of the first year, Baker's Modified Milk is a time-saver for busy physicians and busy hospitals. Simply dilute Baker's to prescribed strength with water.

Baker's Modified Milk is furnished gratis to all hospitals for your use.

FEEDING DIRECTIONS

(Normal dilution for liquid provides 20 calories per liquid ounce.)

	Baker's	Bailed Water
Hospital	1 part	2 parts
First week at hame	1 part	1½ parts
After first week at hame	1 part	1 part

Alsa available in powder farm. (Narmal dilutian one tablespaan ta 2 aunces of water provides 20 calaries per fluid ounce.

*Made from Grade A Milk (U. S. Public Health Service Milk Code)

THE BAKER LABORATORIES, INC.

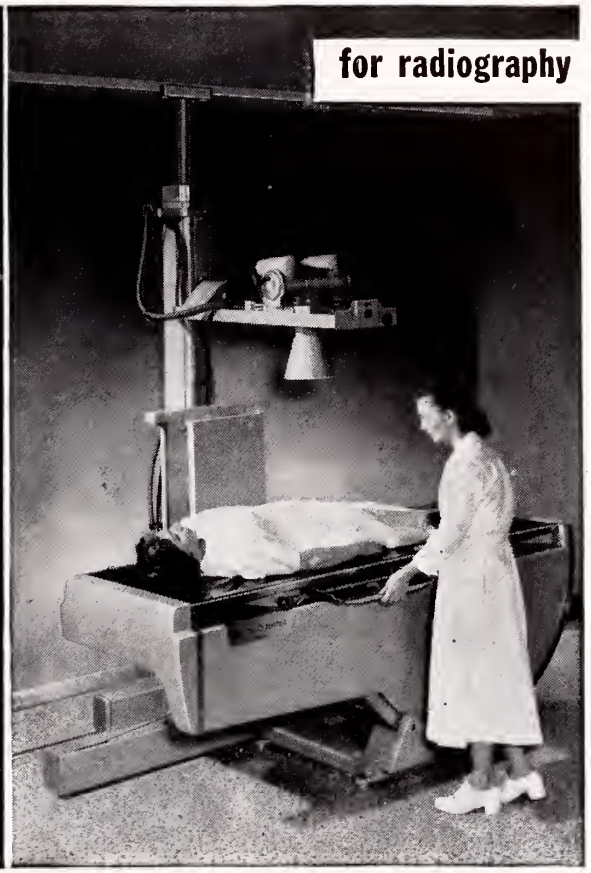
Milk Products Exclusively for the Medical Profession

Main Office: **Cleveland 3, Ohio** • ***Plant:*** **East Troy, Wisconsin**

Now, for only $4950* G. E. brings you complete 200-ma x-ray facilities

*f.o.b. Milwaukee, U.S.A.





New PATRICIAN diagnostic unit — the low-cost x-ray unit with major features you've always wanted. You get 81-inch angulating table • independent tube stand with choice of floor-to-ceiling or platform mounting • 200 ma-100 kvp, full-wave transformer and control • double-focus, rotating-anode tube. But that's not all.

You're equipped for vertical and horizontal radiography — Bucky and non-Bucky technics —even cross-table and stereo views. Focal-film distances up to full 40 inches at any table angle . . . as great as 48 inches cross-table.

The new PATRICIAN features a counterbalanced fluoroscopic unit with full screening coverage. Even the new automatic reciprocating Bucky is counterbalanced — self-retaining in all table positions.

Contact your General Electric x-ray representative for details or demonstration, and be sure to have him explain the G-E Maxiservice® *rental* plan.

Progress Is Our Most Important Product

GENERAL ELECTRIC

Direct Factory Branches:

CINCINNATI — 3056 W. McMicken Ave

LOUISVILLE — 501 West Oak Street

DOCTORS EVERYWHERE NOW KNOW WHY

Viceroys Are Smoother



Professional men who have studied the microscopic analysis of the Viceroy filter now know why the Viceroy taste is smoother—never rough. Only Viceroy has 20,000 tiny filters in every tip—twice as many filters as the other two largest-selling filter brands. That is why Viceroys are smoother by far—never, never rough. That is why so many doctors now smoke and recommend Viceroys.

Yes, smoother taste because there are

TWICE AS MANY FILTERS IN EVERY VICEROY TIP

as the other two largest-selling filter brands!



Viceroy's exclusive filter is made from pure cellulose—soft, snow-white, natural!



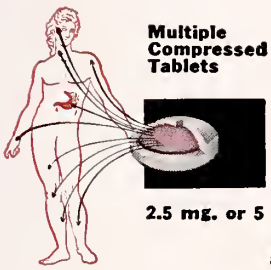
in rheumatoid arthritis



ROUTINE
CO-ADMINISTRATION
MEANS

'Co-Deltra'
(Buffered Prednisone)

'Co-Hydeltra'
(Buffered Prednisolone)



Multiple Compressed Tablets

Clinical evidence[1, 2, 3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

SHARP & DOHME
Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

References: 1. Boland, E. W., *J.A.M.A.* **160**:613, February 25, 1956. 2. Margolis, H. M., *et al.* *J.A.M.A.* **158**:454, June 11, 1955. 3. Bollet, A. J., *et al.* *J.A.M.A.* **158**:459, June 11, 1955.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are the trademarks of* MERCK & CO., INC.

ALL THE BENEFITS OF THE "PREDNI-STEROIDS" PLUS POSITIVE ANTACID ACTION TO MINIMIZE GASTRIC DISTRESS

magnified potency

with Meti-steroid

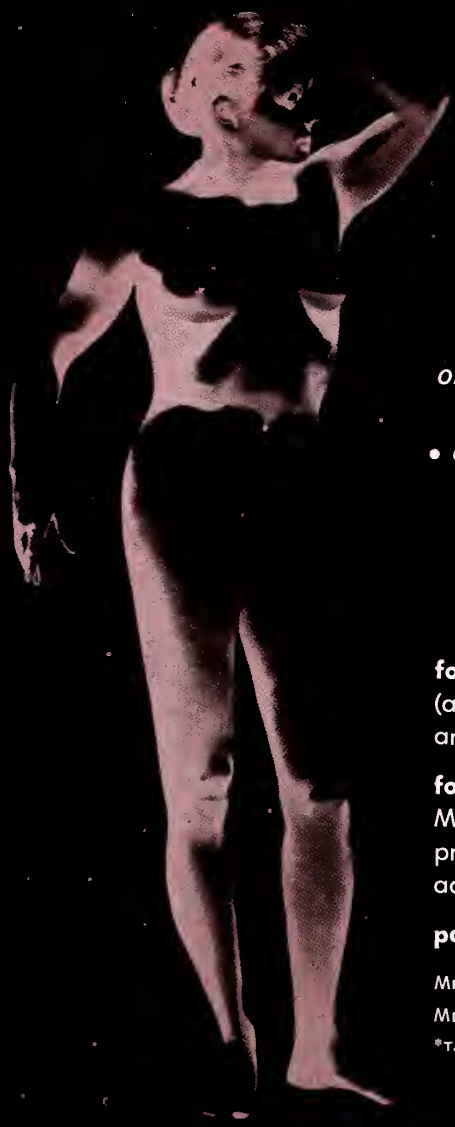
effectiveness in allergic

and inflammatory dermatoses

new

Meti-Derm cream 0.5%

with METICORTELONE, originol brond of prednisolone



- *approximately*

twice the per milligram

anti-inflammatory activity

of topical hydrocortisone

- *cosmetically acceptable*
- *water-washable*

for effective local relief of allergic (atopic and contact) dermatoses, nonspecific anogenital pruritus.

formula: Each gram of water-washable METI-DERM Cream contains 5 mg. (0.5%) of prednisolone, free alcohol, in a cosmetically acceptable base.

packaging: METI-DERM Cream, 0.5%, 10 Gm. tube.

METI-DERM,* brond of prednisolone topical.

METICORTELONE,® brond of prednisolone.

*T.M.

...and adding dual control

to Meti-steroid skin therapy—

protection

against infection

new

Meti-Derm ointment

with Neomycin



enhanced effectiveness

in allergic, inflammatory

dermatoses when

minor infection

is present

or anticipated



neomycin in addition to prednisolone, free alcohol—for protective coverage against virtually all pathogenic skin bacteria with a well-tolerated, *topical* antibiotic.

formula: Each gram of water-washable METI-DERM Ointment with Neomycin contains 5 mg. (0.5%) prednisolone, and 5 mg. (0.5%) neomycin sulfate equivalent to 3.5 mg. neomycin base.

packaging: METI-DERM Ointment with Neomycin, 10 Gm. tube.

Schering

MD-J-656



660005

specify

'Merthiolate'

(THIMEROSAL, LILLY)

'Merthiolate' is highly active under virtually all conditions; is relatively nonirritating and nontoxic

'Merthiolate' is germicidal in dilutions up to 1:4,000 in serum media and is relatively nonirritating in the concentrations suggested for use. It also maintains its activity in the presence of soaps. The fact that 'Merthiolate' is used as a bacteriostatic agent in fluids for parenteral administration gives strong evidence of its safety.

ELI LILLY AND COMPANY

80TH ANNIVERSARY 1876 • 1956

The JOURNAL of the

Kentucky State Medical Association

Issued Monthly Under the Direction of the Council

VOL. 54 JUNE, 1956 NO. 6

INTESTINAL OBSTRUCTION FROM THE RADIOLOGICAL POINT OF VIEW

Everett L. Pirkey, M.D., and Dale Undem, M.D.*

Louisville

THE ROLE of the radiologist in the intestinal obstruction will vary considerably with: 1) The type of obstruction; 2) The condition of the patient; 3) The type of roentgen and surgical facilities available; and, 4) The temperaments of both the radiologist and the surgeon. It is important for all persons concerned in the handling of such cases that the foremost consideration be given to the welfare of the patient. There are a number of ways in which the radiologist can be of considerable help to the surgeon in the handling of his individual cases. We will describe these methods beginning with the simplest and progressing to the more complicated. The simplest method that will achieve the desired result should be preferred in all cases.

Plain Films of the Abdomen

Once the clinical diagnosis of the intestinal obstruction has been reached by the usual methods of history and physical examination, the first roentgen method to be applied is that of obtaining plain films of the abdomen for study of the pattern and distribution of the intestinal gases, determination of the presence or absence of masses, and abnormal solid viscera. These plain films of the abdomen should be obtained with the best radiographic technique and the shortest exposure time to reduce the possibility of motion, either by the patient or his intestine, and thereby obtain good detail and contrast. The intensifying screens and the darkroom procedures should be of the highest quality so that inadvertent artifacts and other darkroom peculiarities do not appear on the films.

Two types of films are customarily obtained:

1. The prone film in which one obtains an excellent demonstration of the distribution of the intestinal gas pattern and, because the patient is horizontal, the gas will float against the mucosal surface of the distended loops, thereby permitting one to determine the level of the intestine which contains the gas. The higher the gas is in the small intestine the more mucosal folds there are present. Typical jejunal distention, (Figure 1.) can be easily differentiated from typical colon distention, (Figure 5.) but, as so often happens, the typical appearance is not always present and considerable experience is necessary for proper evaluation of the gas shadows present in the case at hand.

2. Erect films of the abdomen have as their principal value the determination of the presence or absence of free air in the peritoneal cavity. The free air, if present, will gravitate to the highest point in the abdomen at the time of the examination. This, in the true erect position, will usually be subdiaphragmatic. However, one occasionally sees cases in which the subdiaphragmatic space is filled with an abscess or inflammatory tissue and the air will collect beneath the liver rather than beneath the diaphragm. A lateral decubitus film, with the patient lying on one side and the tube in front and the film behind the patient, will demonstrate the free air along the superior flank. The lateral decubitus position may also be substituted in patients who are too ill to be placed in the erect position. The presence of fluid levels

*Aided in part by a grant from the Kentucky State Medical Research Commission.

in the intestinal tract on films made in the erect position is an interesting finding and is indicative of intestinal stasis but it has been our experience that they are of little value in the differentiation of the type of intestinal stasis present.

If one has the choice of only one of the above types of plain examination of the abdomen, a supine film is usually of considerably more value in differential diagnosis because of the better delineation of the mucosal pattern in the dilated intestine. It is felt that if everyone concerned with the management of intestinal obstruction would take the time to review the supine films with particular interest given to the type of mucosal pattern present, a considerable amount of additional information would be obtained concerning the point of obstruction.

Colon Studies

Studies of the colon by means of an opaque enema are of considerable value in any patient when the history, physical findings, or plain films of the abdomen suggest the possibility that some form of colon disease is the precipitating factor. With the opaque enema administered under fluoroscopic control by an experienced person, there is little danger to the patient. Inasmuch as the enema is administered in a retrograde manner, one need have little fear concerning retention of the opaque material above the point of obstruction. Also, in view of the fact that it is administered under fluoroscopic control, particular attention can be paid to allay the possibility of perforation of the colon in a diseased area. The head of pressure used with the enema in a person with suspected colon disease should be less than 36 inches.

Once the point of obstruction is reached a small amount of material should be allowed to pass through the narrowed lumen, if possible, in an attempt to ascertain the length of the obstructed site. By studying the mucosal changes in the area of obstruction, a definitive diagnosis of conditions such as intussusception of the colon, carcinoma, diverticulitis, or volvulus can often be made.

In a patient with partial obstruction of the colon in which some opaque material will pass proximal to the lesion, it is not recommended that the entire colon be filled. Inspissation of the opaque material, particularly the opaque mixtures of barium sulfate, will occur proximal to the area of obstruction. This may result in the production of a complete colon obstruction and make emergency surgery necessary in a patient who could have been handled as an elective case. The finding of a normal colon in a patient in whom colon obstruction was suspected is of considerable value inasmuch as it changes the method of clinical approach to the patient.

Intestinal Intubation

When the colon has been eliminated as a source of obstruction the possibility of intestinal intubation should be considered, if the patient has the type of intestinal stasis which lends itself to this and the surgeon has the intestinal fortitude to follow through with the procedure in an orderly planned program. The radiologist can be of help to the surgeon in making sure that the tube enters the small intestine. This is done fluoroscopically only in the difficult cases. The intestinal tube is inserted into the stomach and the patient is made to lie in bed on his right side. After a period of time, a study of the secretions removed by the tube will indicate whether or not it has passed through the pylorus into the small intestine. A quick fluoroscopic check can be made of its position but it is not recommended that any prolonged fluoroscopic examination be done because both the patient and his physician may acquire too much radiation during this procedure.

Numerous tricks have been advocated for relaxing the pylorus. They range from the pouring of cold water through the tube against the pylorus to the injection of Kentucky bourbon whiskey. It is felt that the benefits vary with the familiarity of the particular pylorus to the type of material inserted.

When the tube has entered the small intestine, considerable personal attention must be given its function by the surgeon in charge of the case as the small lumen of the tube plus its length lends itself to stoppage by any particles that may enter. The downward progress of the tube is followed by observing 1) the general condition of the patient, and, 2) serial x-ray films of the abdomen made at 24 and 48 hour intervals. A properly handled tube should progress at a fairly steady rate until its tip reaches the point of obstruction. This fact is

ascertained by films made at least 24 hours apart in which the tip has not changed its position. Once the tube is thought to have reached the point of obstruction, we have been injecting an opaque material through the open lumen of the tube into the intestine under fluoroscopic control. During this procedure we can obtain films showing the site and type of obstruction. (Figure 4).

Two things should be emphasized: 1) there is no inherent danger in the injection of an opaque material into an obstructed small intestine because there is no dehydrating action and, therefore, hard lumps of opaque material will not be formed, and 2) it does little good to inject opaque material through a tube until one is certain that the point of obstruction has been reached.

Several illustrative cases are presented.

Figure 1



Case 1. W.B. No. 56083. A 53 year old colored male was admitted with a one year history of a reducible indirect inguinal hernia. Three days prior to admission, the hernia could not be reduced and the patient experienced the sudden onset of nausea, vomiting and cramping abdominal pain. Physical examination revealed a slightly distended tympanitic abdomen in which no peristalsis was heard. A warm mass was palpable in the right inguinal region. Immediate surgery revealed an incarcerated right indirect inguinal hernia with the hernial sac containing a knuckle of proximal ileum. The obstruction was relieved without resection and the patient made an uneventful recovery.

Film (above) shows distended jejunum traversing the upper portion of the abdomen. Note typical appearance of distended jejunum.

Figure 2



Case 2 L.D. No. 198862. A 76 year old white female was admitted with a history of intermittent abdominal pain and vomiting for a three-day period. She had had an umbilical hernia for approximately five years. Physical examination revealed a temperature of 104°, abdominal distention without peristalsis, and generalized abdominal tenderness.

Preliminary abdominal film (above) shows distention of both colon and small intestine typical of adynamic ileus, secondary to generalized peritonitis.

Surgery performed the next day revealed a mesenteric thrombosis with jejunal gangrene, perforation and generalized peritonitis. Resection of the involved intestine was accomplished, but the patient died on the eighth postoperative day.

Case 3. V. P. No. 151375. This 40 year old white male entered the hospital with symptomatology indicating an acute appendicitis. This diagnosis was confirmed at immediate surgery and the first postoperative week was

Figure 3



uneventful. Then intermittent distention and vomiting ensued and persisted until the patient was reoperated 10 days following his first procedure. A loop of terminal ileum 12 inches in length was found to be distended and adhesions were freed at either end of this portion of bowel. The patient made a good recovery.

The film shows the typical circular gas shadow of a closed loop obstruction. Note the absence of the mucosal pattern of jejunum and the haustrations of the colon, therefore this must be ileum.

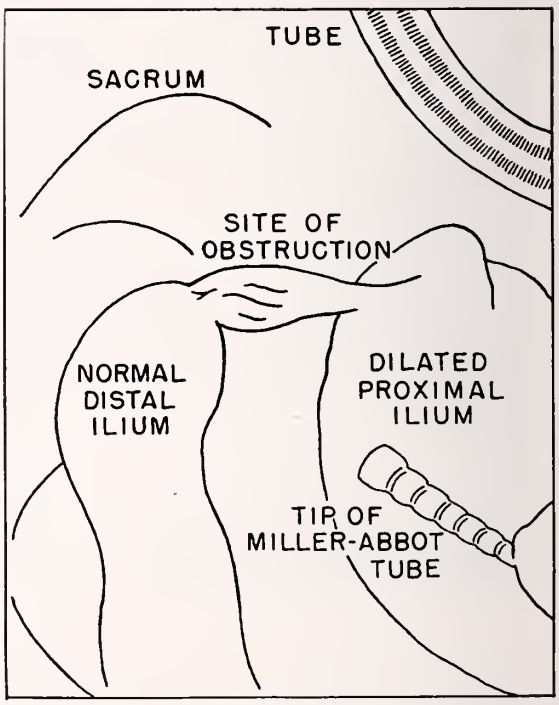
Case 4. J.D. No. 95971. A 55 year old colored female was admitted with a one day history of vomiting and abdominal distention. Physical examination revealed generalized tenderness and the absence of peristalsis. She had had an abdominal hysterectomy 20 years prior to admission.

At surgery two adhesive bands about the terminal ileum were freed and the postoperative course was uneventful.

A spot film of the pelvis shows the tip of the Miller-Abbott tube in the distended ileum proximal to the obstruction. Barium sulfate has been injected through the tube and outlines the narrow site in the center of the illustration as diagrammed. Note barium sulfate in the normal ileum on the left distal to the obstruction.

Figure 4

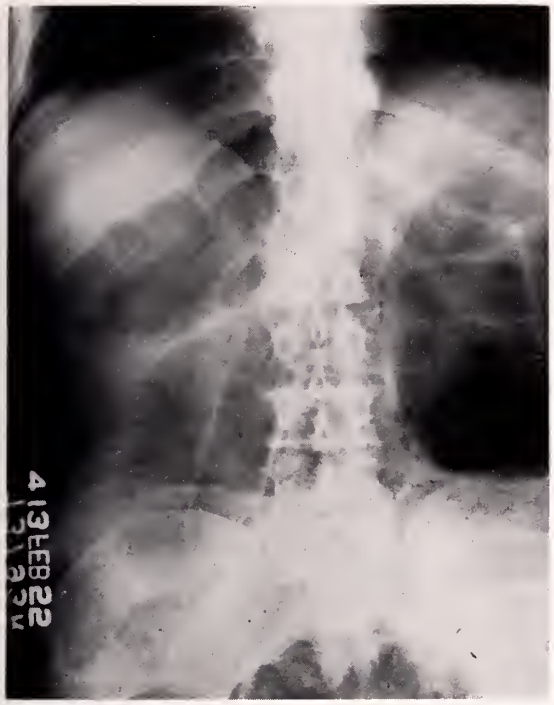




Case 5. H.C. No. 73793. A 66 year old colored male was admitted with a history of cramping abdominal pain, nausea, and vomiting for six hours duration.

Film of the abdomen (below) shows marked colon distention with a portion of the descending colon especially prominent along the left side of the patient's abdomen. Two loops of

Figure 5



small intestine are noted to be moderately distended lying just to the right of the lumbar spine.

Colon examination via barium enema revealed complete obstruction at the junction of the sigmoid and descending colon.

Surgery revealed an adenocarcinoma at that site and resection of the involved portion was done and a transverse colostomy performed. The patient made a good recovery from this procedure.

Summary

1. The role of the radiologist in the handling of intestinal obstruction is reviewed.
2. The relative importance of plain films, colon examinations, and intestinal intubation is discussed and specific indications for each are given.

Bibliography

1. Frimann-Dahl, J.: The Administration of Barium Orally in Acute Obstruction: Advantages with Risks. Acta Radiologica, Vol. 42, October 1954, pp. 285.
2. Sands, W. Wayne: Survey Roentgenograms as Aid in Diagnosis of Acute Abdominal Conditions. Surg., Gynec., and Obst., 97:4-10, July 1953.
3. Martin, James F., Friedell, Hymer L.: Partial Obstruction of the Small Intestine: With Special Reference to the Obstructing Segment. Radiology 59: 49-62, July 1952.
4. Sante, L. R.: Intestinal Obstruction, Paralytic Ileus, Mesenteric Thrombosis and Kindred Lesions. Jr. Mo. Med. Assoc., 48: 889, November 1951.
5. Millins, Harry Z., and Rigler, Leo G.: The Roentgen Findings in Strangulating Obstructions of the Small Intestine. Am. J. Roent., Radium Therapy and Nuclear Medicine, 71:3: 405, March 1954.
6. Pirkey, Everett—Undem, Dale: Roentgen Interpretation of Abnormal Gas Shadows Seen on Plain Roentgenograms of the Abdomen; the American Surgeon, Vol. 22, No. 2, Feb. 1956.

PROLAPSE OF FALLOPIAN TUBE AFTER VAGINAL HYSTERECTOMY REPORT OF THREE CASES

W. O. Johnson, M.D.
Louisville

VAGINAL TUMORS which appear after vaginal hysterectomy may be divided into two groups:

I. Those caused by or arising from vaginal mucous membranes.

a. Enterocele, overlooked preoperatively or postoperatively.
b. Vesicle or enterocele recurrence.
c. Vaginal myomas or fibromas.
d. Gartner's duct cysts.
e. Vaginal inclusion cysts.

II. Others not arising from vaginal mucous membranes.

a. Proliferative granulation tissue (postoperatively).
b. Recurrent malignant lesions.
c. Recurrent papilloma or granuloma.
d. Prolapse of Fallopian tube, following vaginal hysterectomy, with or without drainage.

Despite the fact that only 12 cases of prolapse of the Fallopian tube are reported in the literature, the complication is not particularly uncommon.

The most common complication found on postoperative examination following vaginal hysterectomy is granulation tissue in the dome of the vagina. This occurs in two to 20 per cent of the cases. Healing delayed by granulation tissue around the dome of the vagina at the point of removal of the cervix is found on the lateral walls of the vagina in cases of circulatory disturbance. This granulation tissue is associated with prolonged and profuse vaginal discharge which causes great anxiety in the patient and disturbs the doctor. It promotes the fear of malignancy and is a cause of bleeding after operation. Other complications may cause symptoms until found later by the examining

physician. Another complication, prolapsed Fallopian tube, is more disturbing.

Causes of Prolapsed Fallopian Tube

1. Cul-de-sac damage[5]
2. Poor tissues and difficult operation[3]
3. Infection in postoperative causes[2]
4. Postoperative ectopic pregnancy[3]
5. Interposition operation[1]
6. Inadequate closure in abdomen or vaginal cases with or without drainage.[2]
7. Hematoma

The symptoms of prolapse of the Fallopian tube appear from one to four months after the operation, and consist generally of a persistent, profuse vaginal discharge and pain and tenderness in the dome of the vagina after long standing or on touching the dome of the vagina. After the diagnosis is made, cure of this complication may be effected by vaginal removal of the prolapsed tube.

Report of Cases

Case Number 1: This patient was white, 60 years old, and para viii, gravida viii. She had had a number of years of stress incontinence, with dribbling, irritation and discharge. She complained of backache and bleeding from the vagina for six weeks. After examination the following diagnoses were made:

1. Vaginal prolapse.
2. Chronic cervicitis and ulceration of the anterior wall of the vagina, moderate cystocele and rectocele.
3. Arterial hypertension.

A vaginal hysterectomy and anterior and posterior repairs were done for this patient. She had an uneventful post-operative course of about six weeks. When she returned to my office she had a profuse discharge and some spotting. This was treated with silver nitrate stick and douche for six weeks, then healed by secondary intention.

Case Number 2: This patient was para xiv, gravida xv (one abortion). She had a history of five years of stress incontinence and also complained of difficulty in urination and defecation. She was found to have uterine prolapse, a chronic cervicitis and a moderate cystocele and rectocele. Shortly thereafter she was operated on, a vaginal hysterectomy and anterior and posterior repairs being done. The vaginal packing was withdrawn two days after operation. Four days later she developed cystitis and her temperature rose to 103°. She responded well to the use of Gantrisin,® forced fluids and a sulfa cream. The following day the drain was removed and two days after this she was discharged. Pathology reported chronic cervicitis and hyperplastic endometriosis.

On the patient's first postoperative clinic visit, three weeks after discharge, it was found that the cuff was protruding and tender to touch but did not bleed. This later developed a dime sized area of granulation tissue which was cauterized with silver nitrate. Two months after discharge the patient complained of pains in her lower abdomen. In the vaginal dome there was found a two cm. circular reddish area which when pulled out appeared to be the Fallopian tube. This was amputated about two weeks afterward.

Case Number 3: The patient was 38 years old, para vii and gravida vii. She complained of vaginal bleeding and stress incontinence. Examination revealed cystocele, rectocele and prolapse of the uterus. Vaginal hysterectomy and repair of the cystocele and rectocele were done and following an uneventful course she was discharged. Pathology reported chronic cervicitis and basalis endometrium.

Approximately one month after operation she was found to have some vaginal discharge. Otherwise she was well. Three months postoperatively, the first prolapsed tube was seen and a month later the patient was re-admitted and the tube excised. Following this a purulent vaginal discharge and an area of granulation tissue in the dome of the vaginal cuff persisted in spite of treatment. The other Fallopian tube was pulled out as far as possible, ligated, and excised. A small area of granulation tissue was cauterized. The patient was discharged after the packing was removed. Pathology reported chronic purulent salpingitis. Seven months after the first operation the patient had no complaints and the vault of her vagina was healed.

Discussion

I am sure there are more unreported cases and undiagnosed cases. If the possibility is kept in mind, it will help in the diagnosis of this complication.

A procedure I consider ideal is to put the patient under anesthesia, clean the vagina and pull the tube out as far as possible, cut it off

with cautery or knife and ligate and then allow it to retract into the dome of the vaginal vault. It will then granulate and the discharge will stop.

Some prolapsed tubes can be removed in the office by treating repeatedly with cautery, or by silver nitrate sticks until they granulate in and cover vaginal mucus membrane.

I have never encountered hemotoma of the vaginal dome as a result of this complication, but I have seen it once in the dome of a vagina in which the cuff was not closed in abdominal hysterectomy followed by infection.

Summary

Three cases of prolapse of the Fallopian tube after vaginal hysterectomy are presented. The treatment of this complication is discussed.

Bibliography

1. Kennedy, J. W., and A. D. Campbell. Vaginal Hysterectomy. Philadelphia: F. A. Davis Company, 1942. PP. 172-180-296.
2. Burkeley, C. W., and Victor Bonney. A Textbook of Gynecological Surgery. 4th Ed. New York: Paul B. Hocker, Inc., 1942, P. 847.
3. Bower, J. O., A. E. Pearce, and Conway (E.W.) Prolapse and Torsion of the right fallopian tube with vaginal bleeding following vaginal hysterectomy. American Journal of Obstetrics and Gynecology. 40:1047-1050 (Dec., 1940).
4. Thenig, L. A. Prolapse of Fimbriated End of Fallopian Tube through Operation of Anterior Vaginal Wall. American Journal of Obstetrics and Gynecology 45:876-879. (May, 1943).
5. McElin, Thomas W. Deward O. Ferris. Prolapsed Fallopian Tube as a complication of Vaginal Hysterectomy; Report of Two Cases. Proceedings of the Staff Meeting of the Mayo Clinic. Vol. 24, page 447 (1946).

THE CURRENT STATUS OF BILIARY SURGERY*

HART HAGAN, M. D., F.A.C.S. AND WILLIAM HAGAN, M. D., F.A.C.S.

Louisville

A PATIENT facing cholecystectomy today, can be reassured with the fact that, properly performed under favorable conditions, this operation has become remarkably safe with a mortality rate approaching that of anesthesia alone. The decrease in mortality and morbidity of biliary surgery has been largely the result of better understanding of the normal and pathological physiology of the liver and the relationship of biliary disorders to other functions of the body. The same patient may be justifiably concerned about the rising incidence of common duct injury due to technical errors during cholecystectomy. That there is an increase in common duct injuries occurring throughout the country is established fact and a cause for concern. It must be attributed to one of several factors: qualified surgeons are attempting biliary surgery under handicapping conditions; surgeons are failing to adhere to fundamental principals of biliary surgery; or surgeons not fully qualified for this work are attempting it.

This paper will consider this problem and several other aspects of the current status of biliary surgery.

Gallstone Formation

Why do gallstones form? Since approximately 30 per cent of females and 15 per cent of males past 40 have gallstones and the incidence further increases with age, the discovery of some method of prevention of gallstone formation is far more important than their surgical removal. Gallstones may be composed of cholesterol, bile pigment, bilirubin and calcium in varying combinations, or rarely of calcium carbonate. The common gallstones are 70 to 90 per cent cholesterol. Unfortunately, there is little new knowledge concerning the reason for their formation. Andrews, years ago, described a balance between the solubility of cholesterol in human bile and the concentration of bile acids present. A rise in cholesterol excretion or a decrease in bile acid production by the liver, therefore, sets the stage for stone formation. The initial steps in gallstone formation, being metabolic, should be preventable. Research on this has been difficult due to the lack of satisfactory experimental methods of consistently producing gallstones in laboratory animals. There is an interesting bit of new work along this line from the Sloan Kettering Institute.[3] It was found that hamsters, if fed a cholesterol-free and nearly fat-free diet, especially if deficient in vitamin "A" and vitamin "D", promptly formed cholesterol stones. So we now have an experimental animal and method suitable for studying the various factors involved in gallstone formation. It will be interesting to follow development in this study.

**Presented at a meeting of the Muldraugh Hill Medical Society, April 14, 1955.*

Risks Involved

Which is the greater risk, cholecystectomy or the possible complications of gallstones? Our present mortality rate for cholecystectomy is 0.3 per cent. This approaches the mortality rate of anesthesia alone. Nevertheless, all of us are seeing increasing numbers of elderly patients, many in their eighties with serious complications of neglected gallstone disease: namely, acute cholecystitis, pericholecystic abscesses, bile peritonitis, common duct obstruction, cholangio-hepatitis, pancreatitis, cholecystenteric fistulae, etc. The relationship of gallstones to carcinoma of the gall bladder has never been definitely established but nearly 100 per cent of patients with carcinoma of the gall bladder have gallstones. They are under considerable suspicion as etiological agents in cancer production. Therefore we feel, under most conditions, gallstones producing symptoms should certainly be removed. Even when age or other conditions increase the surgical risk, careful thought must be given to the fact that the risk of complications from gallstones is also increased under these same conditions. A gangrenous gall bladder or obstructive jaundice in an elderly patient is a major threat to his life.

Should the "silent" stone be removed? No gallstone, of course, is normal; likewise, no gallstone is truly "silent." However, many people carry gallstones all their lives without serious complications. There is a definite risk involved by the presence of gallstones. There is also a certain amount of risk involved in their surgical removal. In general we feel the younger the patient, the better the surgical risk, the greater the indication for prophylactic cholecystectomy for so called "silent" stones. If a relationship to carcinoma of the gall bladder is finally established, there may be an even stronger indication for their removal in elderly patients.

Is it ever justifiable to remove a non-calculous gall bladder? Rarely is a patient benefitted by the removal of a non-calculous gall bladder. Ninety-eight per cent of the gall bladders removed in our series have contained stones. If no stones are present, look elsewhere for the cause of the symptoms.

Has radical surgery improved the prognosis in carcinoma of the gall bladder and bile ducts? In the past, the diagnosis of carcinoma of the gall bladder or bile ducts has almost invariably spelled doom for the patient. In an attempt to combat this, more and more radical surgical procedures have been attempted. Wide resections involving lobes of the liver, pancreas, stomach, duodenum and node bearing areas have been performed. To date the results do not seem to justify this approach except in early lesions about the ampulla of Vater or head of the pancreas. Prophylaxis by removing calculous gall bladders and other sources of biliary disease seems the most promising attack on this problem at present.

Acute Cholecystitis

What is the present attitude concerning the treatment of acute cholecystitis? We believe that patients seen early with acute cholecystitis should be operated on at that time. The reason is as follows: It is true that only a small percentage of patients having acute cholecystitis will perforate if treated conservatively. However, 10 per cent of those patients who die following cholecystectomy do so because perforation had already occurred. Early operation should save these.[2]

Hospital expense is lessened. The patient is usually well and ready for discharge in less time than it takes acute cholecystitis to subside. Many patients treated conservatively will not return for elective surgery until more serious complications arise. This increases the risk which they must undergo. While awaiting elective cholecystectomy, recurrent acute attacks are prone to occur.

Finally, mistakes in diagnosis do occur. It is not difficult to confuse acute cholecystitis with other conditions requiring prompt surgical attention. So we favor early surgery for acute cholecystitis with this very important provision; the surgeon must not persist in an attempt to perform cholecystectomy if an inflammatory reaction obscures structures about the cystic common duct junction! Cholecystostomy remains the safest procedure under adverse conditions. If cholecystostomy is performed, it must not be considered curative. After cholecystostomy alone, one third of the patients will continue with severe symptoms and five to six per cent will die because interval cholecystectomy was not performed.[1] Unless clearly contraindicated by the condition of the patient,

cholecystostomy should always be followed by elective cholecystectomy.

Human Error Risk

How great is the risk of human error in cholecystectomy? Lahey is quoted as saying that he would rather see a surgeon of limited experience undertake a gastric resection than a cholecystectomy since he was somewhat less likely to get into serious trouble. It is unfortunate that the term "simple cholecystectomy" has come into use. The truth is, that prior to operation and exposure, no surgeon can anticipate what will be found, what need be done, nor how difficult it will be to do it. There are few areas as subject to variations in anatomy, anomalies of the ducts and vessels and unexpected pathology. Even in the absence of unexpected difficulties, inadequate lighting, improper exposure, insufficient help or unsatisfactory anesthesia may put the best of surgeons at a great disadvantage and result in error.

Lack of familiarity on the part of the surgeon with anomalies in the region of the gall bladder is courting trouble. The cystic artery may arise from any of the nearby vessels. It commonly comes, of course, from the right hepatic artery which crosses behind the common duct. It may arise from the left hepatic artery, the common hepatic or the gastro-duodenal. There may be one or more accessory cystic arteries of considerable size. Perhaps the most dangerous anomaly is the right hepatic artery, which, arising from the superior mesenteric or else dipping down from its usual position, comes to lie very close to the cystic duct and gall bladder.[7] In a series of autopsy examinations, the right repatic was found within one cm. of the cystic duct in 10 per cent of cases. Despite the recent flurry of articles on hepatic artery ligation for portal hypertension and the ability of antibiotics to lessen the mortality rate of hepatic ischemia, ligation of any major part of the blood supply of the normal liver is still quite likely to result in a mortality.

Hemorrhage from a torn cystic or hepatic artery can produce a fairly disquieting situation. However, when it happens, the disaster has not yet occurred. It is the surgeon frantically, blindly clamping who includes common duct or hepatic artery in his grasp who provides the real problem. The proper maneuver is to occlude the hepatic artery with a finger in the foramen of Winslow while careful exposure and control is obtained.

The final source of danger is error in judgment. As already mentioned, cholecystectomy is being performed more and more frequently for acute cholecystitis. This is desirable, but the surgeon must not attempt cholecystectomy when the cystic common duct junction and structures in the gastro-hepatic ligament are obscured by inflammatory reaction. Under these conditions, cholecystostomy is the procedure of choice.

Common Duct Injury

How significant is the problem of common duct injury? The Lahey Clinic reports 360 cases of common duct injury,[8] the Mayo Clinic 325 cases,[11] and Ann Arbor 160 cases. All large clinics and many surgeons are aware that the frequency of these injuries is increasing. There have been 45 admissions to Louisville hospitals within the past five years with a diagnosis of common duct injury.

What does common duct injury mean to the patient? The following case will serve as an example. A patient in her forties had a cholecystostomy and later a cholecystectomy. Following cholecystectomy, jaundice developed. After a period of time, the surgeon attempted an anastomosis between the duodenum and common duct; this failed to function and the patient was referred to us. There followed a series of operations attempting to relieve the patient's repeated bouts of obstructive jaundice and liver damage. In summary, she was admitted to the hospital 13 times; had 10 operations; spent 275 days in the hospital; was troubled with jaundice for the greater part of five years, with death as the final outcome. Her expense, excluding professional fees, was estimated to be over $10,000.00 These patients may face multiple operations, repeated bouts of common duct obstruction, progressive liver damage, utold suffering, expense, long illness and finally death. Everyone doing cholecystectomies should bear this picture in mind. If injury to the common duct does occur, the sooner it is recognized and properly repaired, the better the chance for a good result. The best opportunity for repair is at the time of injury. However, this is considered by many, the most

difficult of all abdominal surgery. Unless one is certain of one's ability and unless working conditions are ideal, it may be wiser to defer repair until these conditions can be met.

Errors of Omission

Appreciating this hazard of common duct injury, the conservative surgeon may err on the other side and do too little rather than too much. There are three rather common instances of this: The long cystic duct stump, the overlooked common duct stone, and the overlooked abnormality at the ampulla of Vater.

If the cystic duct is not ligated close to the common duct, or if a portion of the gall bladder is left behind, these are quite apt to produce symptons later. In such cases intravenous cholangiography with Cholgrafin® may visualize the common duct and show the dilated cystic duct stump. Following its removal, many such patients have become asymptomatic.

Cholografin was developed under the name Biligrafin by the Swedes and Germans and began to arouse interest in this country about two years ago. It is an Iodine-containing compound; the technique of its use is not difficult. The hepatic and common ducts will visualize in 90 per cent of cases in the absence of a functioning gall bladder. The use of this drug is contraindicated in the presence of jaundice, severe renal or liver disease or allergy. It is of greatest value in studying the patient who continues to have symptoms following cholecystectomy and in whom a common duct stone is suspected.

The overlooked common duct stone is a major technical problem in biliary surgery. Aside from a careful history and palpation at operation, we have felt that operative cholangiography was the one most helpful method of avoiding this error. We now use it routinely with nearly every cholecystectomy.[6] A catheter is inserted through the cystic duct; Diodrast® is injected and X-rays taken. Occasionally an operative cholangiogram will reveal common duct stones in cases with no history of jaundice, chills or fever with an apparently normal common duct without palpable stones.

Gallstones and Angina Pectoris

What is the relation of gallstone disease to angina pectoris? Recently reviewed by Ravdin,[10] this may be summarized as follows: Evidence now definitely indicates that reflexes arising in the extrahepatic biliary ducts can cause spasm of the coronary vessels. In some cases, definite electrocardiographic changes return to normal following adequate biliary surgery. The uptake of radio-active sodium from the cardiac muscle is reduced by the distention of the biliary ducts in the experimental animal. Patients with gallstone disease may have angina-like symptoms without having cardiac disease. These symptoms are relieved by appropriate biliary surgery. True coronary disease may be aggravated by reflexes arising in the extrahepatic ducts. Because of these facts, the coexistence of cardiac and biliary disease is now considered an indication for biliary surgery rather than its contraindication. This, of course, does not apply in the presence of recent infarct or acute decompensation.

Pancreatitis

Can biliary tract surgery benefit acute or chronic pancreatitis? The etiology of pancreatitis is not finally established. Evidence available strongly indicates that reflux of bile into the pancreatic ducts due to a stone impacted in the ampulla of Vater or spasm of the sphincter of Oddi can be an etiological factor. We feel that if the diagnosis of acute pancreatitis is established by a significant serum amylase evaluation, medical management is the treatment of choice. All of these patients, however, before discharge, should be carefully studied for gallstone disease. It stones are present, cholecystectomy and common duct exploration should be performed with particular attention to the region of the sphincter of Oddi. Even if stones are not demonstrated and recurrent attacks of pancreatitis occur, common duct exploration with operative cholangiography should be performed. If spasm or stenosis of the sphincter of Oddi is demonstrated, a sphincterotomy should be performed.

Gallstones and Other Conditions

What is the relationship of pregnancy to gallstone disease? Cholelithiasis is not at all limited to women fair, fat and forty. Thin young ladies in their twenties frequently are found to have gallstone disease. Almost invariably the onset of symptoms closely follows pregnancy. Older women with a long history of cholecystitis frequently relate the onset of symptoms to pregnancy. Available data indi-

cates that the cholesterol content of gall gladder bile is increased and the bile salt decreased during pregnancy.[9] These are the conditions which theoretically favor gallstone formation. It may be that some method of control of cholesterol metabolism during pregnancy will prove to be one means of preventing gallstone formation.

Diabetes and gallstone disease often coexist and the incidence seems to be increasing. Diabetes is frequently first discovered when the patient enters the hospital with cholecystic disease. Each condition is detrimental to the management of the other. The effect of infection anywhere upon the stability of diabetic control is well known. Less well appreciated is the fact that many patients with biliary disease have longstanding secondary hepatitis. These patients have seriously reduced reservoirs of liver glycogen. Being unable to rapidly mobilize glucose, a dose of insulin, which in the usual diabetic would have but little effect, may precipitate insulin shock. In the elderly patient this may be hazardous. The management of these patients requires the knowledge of both diabetes and pathological physiology of the liver. With proper management, biliary surgery can be performed in most diabetics with little or no increase in risk. There is more reason for removing gallstones from a diabetic than from a comparable non-diabetic.

What is the effect of biliary disease on renal function? The term hepato-renal syndrome is often used. This is a confusing and not very helpful label. The facts regarding combined liver and renal disease may be summarized thus: bilirubin causes a degeneration of the epithelial cells of the renal tubules. Patients with obstructive jaundice, therefore, often have varying degrees of nephrosis. When the jaundice is relieved, the changes which have been limited to the tubules are usually reversible. Patients who die of combined liver and renal damage usually show glomerular changes indicating pre-existing renal disease. Certain toxic agents and diets which produce cirrhosis frequently cause simultaneous liver and renal injury. The importance of the renal factor in biliary surgery must not be underrated. Preoperative evaluation to determine pre-existing renal disease, early relief of obstructive jaundice to lessen renal damage, and close attention to renal function in the postoperative period are essential. Mortality in biliary surgery not infrequently is due to renal failure.

Liver Function

How important is liver function in biliary surgery? No other organ is as capable of regeneration as is the liver. Conversely, few organs are as susceptible as the liver to a wide variety of noxious agents. It is now well established that the nutritional intake of the patient can protect the liver from injury, or if inadequate, can be such as to make it maximally susceptible. Glycogen, per se, does not protect the liver. The susceptibility to hepatic damage increases with the concentration of hepatic fat. A high protein, high calory diet including enough fat to be palatable seems to afford the optimum protection.[4, 5] In patients, over 200 grams of protein a day and over 3,000 calories per day may be required. If they cannot take this amount orally, they should be tube fed. Of conditions which injure the liver, anoxia in some form is probably most frequently encountered during operation. The effect is the same whether it be due to poor anesthesia, respiratory depression, shock or obstruction of the arterial supply of the liver. It may not be generally appreciated that dilatation of the stomach can cause impaired circulation of the liver and produce a picture histologically indistinguishable from that caused by choroform poisoning. This, however, is the important point—the more protein depleted the subject prior to exposure, the greater will be the degree of liver injury. The better the diet, more rapid will be the repair.[5]

Summary

1. As with several other conditions, in gallstone disease the surgeon is temporarily treating a condition which should be prevented rather than cured.

2. Properly performed under ideal conditions, bilary surgery has become remarkably safe.

3. Unfortunately, the rising incidence of serious complications due to technical errors indicates that considerable biliary surgery is being done under less favorable conditions. The price paid by the patient is great.

4. Improved methods of cholecystography, intravenous cholangiography and operative

cholangiography have increased the accuracy of diagnosis of biliary disease.

5. Proper management of patients with biliary disease requires knowledge of the role of nutrition in protecting the liver from injury and aiding its repair. Knowledge of the close relationship of biliary disease to coronary artery spasm, to pancreatitis, to pregnancy, to diabetes and to renal function is important.

Bibliography

1. Donal, J. G. and W. T. Fitts, Jr.: Cholecystostomy. Am. J. Surg. 99:922, 1949.
2. Fletcher, A. G. and I. S. Ravdin, Perforation of the gall bladder. Am. J. Surg. 81:178, 1951.
3. Fortner, J. C.: Experimental studies of gallstone formation. Surgery. 36:932, 1954.
4. Goldschmidt, S. H., H. M. Vars, and I. S. Ravdin: The influence of the foodstuffs upon the susceptibility of the liver to injury by Chloroform and the probable mechanism of their action. J. Clin. Investigation. 18:277, 1939.
5. Gurd, F. N., H. M. Vars and I. S. Ravdin: Composition of the regenerating liver after partial hepotectomy in normal and protein depleted rats. Am. J. Physiology. 152:11, 1948.
6. Hagan, Hart and William H. Hagan: Some Problems of biliary tract surgery. J. Ky. State Med. Association. 52:171, 1954.
7. Johnston, E. V. and B. J. Anson: Variations in formation and vascular relationships of the bile ducts. Surg. Gyn. Obst. 94:669, 1952.
8. Lahey, Frank H.: Prevention and repair of injuries to the bile ducts. Postgrad. Med. 15:212, 1952.
9. Ravdin, I. S.: Surgical diseases of the extra hepatic bile ducts. New Eng. J. Med. 220:326, 1939.
10. Ravdin, I. S., Thomas Fitzhugh, Jr., and C. C. Wolfuth: The relation of gallstone diseases to the symptoms of angina pectoris. Presented at the meeting of the American Medical Association, June, 1954.
11. Walters, Waltman: Physiological studies in cases of stricture of the common bile duct. Ann. Surg. 138:609, 1953.

PHEOCHROMOCYTOMA

Russell A. Del Toro, M.D.*
Louisville

In 1886 the German Fränkel[1] described the finding of bilateral adrenal tumors in a girl 18 years of age who had a history of paroxysms consisting of palpitation, dizziness, headaches and pallor and died suddenly in collapse. However, it was not untill 1922 when the Frenchmen Labbe, Tinel and Doumer[2] described the syndrome of paroxysmal hypertension associated with pheochromocytoma. In 1927 Charles Mayo, M.D., was the first to remove surgically with success one of these tumors. It was not until 1928 that Pincof,[3] diagnosed preoperatively this condition. In 1937, Beer, King, and Prinzmetal,[4] described a case with the demonstration of a pressor substance, adrenalin, in the blood of a patient with pheochromocytoma.

During the past 10 years, since the introduction of more specific tests to corroborate the diagnosis of this curable type of hypertension, the literature on this subject has grown at an increasing pace. The diagnosis is being made more and more often during the patient's life, and the practicing physician has grown more aware of this condition. "Careful consideration of the possible presence of a pheochromocytoma or a paraganglioma in every patient with hypertension, sustained or intermittent, must now be regarded as a diagnostic obligation."[3]

It is the purpose of this paper to review the pathologic physiology, clinical aspects, special diagnostic procedures and treatment of this condition.

Pathologic Physiology

I. Developmental Anatomy of the Adrenal Medulla.

The adrenal glands are developed from two sources; the cortical portion from the mesoderm, the medullary portion being of ectodermal origin.

The neuro-ectoderm of the neural crest gives rise to the primitive ganglionic cells. These are later on differentiated into sympathoblasts which give rise to the ganglion cells of the sympathetic nervous system and into pheochromoblasts which give rise to the chromaffin system. The primitive pheochrome element becomes separated from the ganglions and migrates to the region of the cortex, subsequently aggregating in its center. In this migration, sympathoblasts are carried along and give rise to the ganglion cells within the gland. Similarly, pheochrome cells are diverted from their course and become permanently associated with some of the prevertebral and peripheral sympathetic ganglions as small

*Sponsored by the VA and published with the appoval of the Chief Medical Director. The statements and conclusions published by the author are a result of his own study and do not necessarily reflect the opinion or policy of the VA.

masses of accessory medullary tissue. The pheochromoblasts probably do not become finally differentiated into the mature pheochromocytes until after birth. At this time, these cells, now mature, undergo a chemical change which makes them assume a brown color when treated with chrome salts such as potassium bichromate. Hence these cells are called chromaffin or pheochrome cells.

Tumors arising from these cells were described by various names, e.g., sarcoma, angiosarcoma, perithelioma, carcinoma, etc., until Alezais and Peyron in 1908 described a chromaffin cell tumor originating from a paraganglion in the sacrococcygeal region and gave the name of paraganglioma to all such tumors wherever they were found. Pick, however, in 1912, called attention to the fact that these tumors should be named after the predominating type of cell, namely, pheochromocytomata.

II. Secretions of the Adrenal Medulla and Other Chromaffin Tissues.

The chromaffin tissue is able to produce epinephrine and/or nor-epinephrine Physiologically, the chromaffin tissue can be caused to liberate these substances only in response to impulses reaching it by preganglionic (cholinergic) thoracolumbar nerves.[5] In nearly every situation in which these substances are liberated, an emergency exists, and they cause changes tending to improve the organism's chance of survival.

Although the exact way by which these substances are formed is not definitely established, tyrosine and phenylalamine are most likely their precursors. By a series of dehydrogenation reactions nor-epinephrine is formed from these amino-acids. Epinephrine, in turn is probably formed by methylation of nor-epinephrine. Pitcavin and Youmans[6] among others, have shown that both epinephrine and nor-epinephrine are found in the normal adrenal medulla; however, there is more epinephrine than nor-epinephrine. By continuous stimulation of the splanchnic nerves the amount of epinephrine is gradually diminished, while the amount of nor-epinephrine increases. They also found that generally the amount of nor-epinephrine in adrenal medullary tumors is much greater than in normal adrenal tissue. They believe that this is conclusive proof that nor-epinephrine is an intermediary product of epinephrine.

In 1937, as stated previously, Beer, King and Prinzmetal,[4] described a case of pheochromocytoma in which they were able to demonstrate a hyper-epinephrinemia preoperatively, and later on, the absence of excess epinephrine® in the blood postoperative. In 1949, Goldenberg, Faber, Alston and Chargoff[7] in this country, and Halton[8] in England, demonstrated the presence of nor-epinephrine® in adrenal medullary tissue and in tumors of the adrenal medulla. It is now definitely established that these tumors secrete large amounts of these substances and that the clinical picture of the disease is the direct result of this.

The chemical difference between epinephrine and nor-epinephrine is very slight. Epinephrine has a methyl radical which nor-epinephrine lacks. Nevertheless, the pharmacologic properties of both substances are quite different. The following table, reproduced from an editorial in the Annals of Internal Medicine of December 1953,[3] summarizes very adequately these differences as far as the clinician is concerned in respect to pheochromocytoma:

	Epinephrine	*Nor-epinephrine*
(1) Blood vessels	Vasodilator	Vasoconstrictor
(2) Blood pressure	Systolic elevated	Systolic & diastolic elevated
(3) Cardiac output	Marked increase	Unaffected
(4) Heart rate	Tachycardia	Bradycardia
(5) Symptons	+ + + +	+ −
(6) B.M.R.	+ +	+ −
(7) Blood sugar	+ +	+ −

III. Pathologic Anatomy.

The gross pathologic anatomy of these tumors varies and many times cannot be differentiated grossly from other tumors occurring in the same regions. In the perirenal area, however, there is found in most cases, at the time of operation, a brownish discoloration of the renal fat that should make the surgeon suspicious of pheochromocytoma, if it has not already been suspected on clinical grounds.

A. Location. In 1951, Graham[9] after reviewing 198 cases from the literature and nine cases of his own, a total of 208 cases, concluded that 95.6 per cent of all pheochromocytoma were found in the abdomen and that 89.4 per cent were in the adrenal gland; 90 per cent were single and 10 per cent multiple.

B. Size of the Tumor. This also varies markedly, from a few milligrams to many grams. There is no direct correlation between the size of the tumor and the clinical manifestations and duration of symptoms of the disease.

C. Malignancy. All pheochromocytomata should be considered to be clinically malignant, inasmuch as they can cause organic changes capable of causing death. However, oncologically only 24 (or 11 per cent) of the 207 cases received by Graham[9] were histologically malignant. Although there is no definite relationship between the histological malignancy of the tumor and the symptomatology there are relatively more symptomless cases in this group than in the benign group.[10, 11] Malignant tumors are very difficult to differentiate histologically from benign ones, the best criteria for malignancy being metastasis and local extension.[11] It is speculated that malignant tumors are less apt to produce symptomatology on the basis of being less differentiated and so less able to produce excessive amounts of catecholamines.[11]

Histologically they are formed of polygonal cells arranged in cords and having a striking resemblance to liver tissue except for the lack of formation of lobules.[12] Characteristically they stain brown with chrome salts, that being the basis for the name of chromaffin cell tumors.[12]

Clinical Aspects

Because of the many and different pharmacologic effects of epinephrine and nor-epinephrine the symptoms and signs of pheochromocytoma may vary markedly from case to case. It has been referred to by some authors as the "perfect mimic"[3] and by others as the "goiter of the abdomen."[13]

1. Incidence. Yearly, 175,000 deaths in this country are caused by hypertension and it has been estimated that 800 of these are the result of pheochromocytomata.[9,14] It is considered to be the most common cause of surgically correctible hypertension. Smithwick, at laparotomy with the purpose of performing thoracolumbar sympathectomy in 1,700 hypertensive patients, discovered eight cases of pheochromocytoma, an incidence of .43%.[9] In 15,984 autopsies performed at the Mayo Clinic, 15 cases of pheochromocytoma were found. Allen[15] in performing pharmacologic tests in 730 patients with hypertension suspected of pheochromocytoma established the diagnosis in 12 cases.

There is apparently no sex difference in the incidence of this condition. Of the 207 cases reviewed by Graham[9] 94 were males and 112 females, the sex of the other case was not specified.

Pheochromocytoma may occur at any age; cases have been reported in infants and in elderly people. The youngest case on record was an infant five months old and the oldest a patient 72 years of age.[9] However, the peak of incidence is quoted from several authors as being during the fifth decade.

II. Symptoms and Signs of Pheochromocytoma.

Although there are reports of cases of pheochromocytoma without hypertension[16] this sign is perhaps the most constant of all. Hypertension may be of a paroxysmal type, of a sustained character mimicking essential hypertension, or sustained with episodes or paroxysms in which the already elevated blood pressure becomes acutely more marked. Although Graham in his review of cases reported[9] that only about 25 per cent of these had persistent hypertension, and 75 per cent hypertension of the paroxysmal type, most other authors believe that the incidence of sustained hypertension is much larger and such cases probably were previously misdiagnosed as common cases of essential hypertension.

In 1934, Belt and Powell[17] in reporting a case of pheochromocytoma and reviewing 60 other cases from the literature, first gave the name of sympathetic suprarenal syndrome to the paroxysmal attacks observed in these cases. They stated that the majority of the patients showed instability of the sympathetic nervous system and compared the symptoms to those observed when large amounts of epinephrine were injected.

According to Smithwick[18] and other writers the symptoms and signs of pheochromocytoma may be summarized as follows:

1. Excessive Sweating. This is seen in 50 to 90 per cent of all cases of pheochromocytoma but is seen in only 2 per cent of cases of essential hypertension. It is more pronounced in cases with the paroxysmal type of hypertension, coming at the end of the paroxysmal attack. It is generalized in distribution. He explains this as being both a direct calorigenic effect of the catecholamines and an indirect

effect. The catecholamines produce vasoconstriction which in turn causes retention of heat. This in turn stimulates the parasympathetic center, the cholinergic fibers of this stimulating the sweat glands to produce sweat as a compensatory cooling effect.

2. Peripheral Vasomotor Phenomena. These consist of sporadic evidence of vasoconstriction such as coldness of the hands and feet, blanching of the fingers, mottling and bluish red discoloration of legs and hands, numbness and tingling of the extremities, low skin temperature and marked skin pallor, disappearance of peripheral pulses, and constriction of the retinal arterioles and are all due to cutaneous arteriolar vasoconstriction. These findings occur in about 50 per cent of the cases of pheochromocytoma and in only 2 per cent of the cases of essential hypertension.

3. Elevated Body Temperature. This is due to vasoconstriction with interference with the heat elimination and also to a direct effect of epinephrine causing an increased caloric output. These elevations of body temperature are sporadic and not necessarily related to paroxysmal symptoms. It is manifested as an unexplained fever of 1° F. above normal body temperature or more. During a paroxysmal attack the temperature may go up to 105° or more. This hyperpyrexia is found in about 70 per cent of the cases of pheochromocytoma and only in about 10 per cent of the cases of essential hypertension.

4. Normal Cold Pressor Response. In 1932 Hines and Brown[19] described an abnormal response to cold stimuli found more often in hypertensive than in normal subjects. They found that these patients responded to the immersion of one hand in ice water for one minute by an excessive rise in blood pressure and concluded that a rise of 20/15 or more was abnormal. They found that this test was normal in only 10 per cent of patients with hypertension. Smithwick reports it to be normal in 60 to 70 per cent of cases of pheochromocytoma.

5. Fasting Blood Sugar of 120 mgm. Per Cent or More. Smithwick reports that 60 to 65 per cent of pheochromocytoma cases show a blood sugar of 120 mgms. per cent or more while only 10 per cent of all cases of essential hypertension show this. This finding may be sporadic or persistent. It is usually accompanied by glycosuria and a diabetic type of glucose tolerance curve. It is due to the effect of epinephrine of mobilizing preformed carbohydrate in the liver and muscles.

6. BMR of + 20 Per Cent or More. An increased basal metabolic rate of + 20 per cent or more was found to be present in 55 to 60 per cent of the cases of pheochromocytoma and in only five per cent of the cases of essential hypertension. This was found to vary greatly in the same individual at different times depending on variations of outpouring of epinephrine. These patients are easily differentiated from those with hyperthyroidism in that although at times they may show an abnormal protein bound iodine, their radio-active iodine uptake is always normal.

7. Postural Hypotension and Tachycardia. Smithwick [20,18] recorded the blood pressure and pulse every minute for five minutes with the patient recumbent, sitting and standing. He found postural hypotension in only three per cent and postural tachycardia in only 15 per cent of hypertensive patients, while he found them in 45 to 50 per cent of all cases of pheochromocytoma. There is no definite physiological explanation for these phenomena, although Smithwick postulates[18] that it is probable that this is due to a decrease in venous return to the heart in the upright position. This in turn is due to alterations in the blood flow such as splanchnic and muscular vasodilatation of humoral origin which take precedence over normal vasoconstrictor mechanisms involving the autonomic nervous system that are called into play when one assumes the upright position.

8. Glycosuria. This occurs in 40 to 50 per cent of the cases of pheochromocytoma but in only four per cent of cases of hypertension.

9. Paroxysmal Attacks. These attacks are characterized by severe hypertension, headache, palpitations, pain in the abdomen, chest and extremities, nausea and vomiting, drenching sweats and exhaustion. These attacks occurred in 75 per cent of the cases in the literature but in only 36 per cent of Smithwick's cases. There is a small percentage of cases of essential hypertension that may show similar attacks without having pheochromocytoma. These are due to outbursts of diencephalic activity whose precipitating cause is unknown.

10. The Presence of an Abdominal Mass. This may be detected in about one third of all

cases of pheochromocytoma when careful and repeated examinations of the abdomen are done. In a few instances the tumor itself may be palpated, but in most the mass consists of the downward displaced kidney. Extreme care must be exercised in palpating the tumor in a suspected case of pheochromocytoma for a fatal attack may be induced by massage of the tumor mass stimulating it to produce large quantities of catecholamines. Attacks may be also precipitated by other physical stress on the tumor such as assumption of a particular position of the patient. This was recorded in 43 of the 207 cases of Graham.[9]

11. Funduscopic Changes. Funduscopic examination recorded in 120 cases[9] showed normal findings in 25, arteriolar spasm in 12, A-V nicking in 10, hemorrhage and exudates in 47, and papilledema in 26.

12. Cardiac and Renal Changes. The heart was found to be enlarged in 65 of 125 cases[9] and albuminuria was present in 90 of 132 cases.[9] Green[21] in reviewing 50 cases in 1946 found definite cardiac enlargement in 17 cases, and autopsy of 18 cases revealed myocardial hypertrophy in 15. He also found altered renal function in 24 of the 37 cases of persistent hypertension in his group, consisting of albuminuria in 20 cases, subnormal phenolsulphthalein excretion in 11 cases, abnormal urinary sediment in 10 cases and azotemia in two cases. Sayer, Moser and Mattingly[22] reported the EKG changes in two patients and reviewed the literature on the subject. They found abnormalities of rhythm ranging from simple sinus tachycardia to the more dangerous ventricular tachycardia and abnormalities of the heart muscle suggesting strain, ischemia or damage. Characteristic of this last group of changes was a diffuse distribution of T wave abnormalities consisting of inversion of T waves in all leads. They explained these changes on the basis of direct effect of hyperepinephrinemia on cardiac muscle causing arrhythmias, increase in pulmonary artery pressure with resultant increase in work of the right ventricle and patterns similar to acute cor pulmonale, and by changes in metabolites and electrolytes, especially potassium. Most of these changes disappear after operation; however, some persist and are explained on the basis of permanent diffuse myocardial damage that can be detected at autopsy.

13. X-ray Evidence of Tumor. X-ray changes are relatively rare and depend on the size of the tumor. They are produced by displacement of the renal shadow by the tumor mass. Perhaps the most helpful and easily performed of all x-ray studies are the simple flat plate of the abdomen and the intravenous pyelogram. Perirenal air insufflation and presacral oxygen injections are dangerous and at the present time, with the development of simple chemical and pharmacologic tests and better surgical approaches, they are not essential.[45]

14. Gastrointestinal Complaints. Schwarzhoff[23] in reviewing 210 cases stresses the importance of gastrointestinal complaints which may simulate in some instances acute abdominal emergencies and in others peptic ulcer. He describes the x-ray finding of displacement of the duodenum in some cases when doing gastrointestinal x-ray studies. Kvale cites Miles in reporting two cases of upper gastrointestinal bleeding of unknown origin[24] in which hypertension was noted and both pharmacologic studies and operation revealed pheochromocytomata.

15. Adrenal Cortical Dysfunction. The excessive growth of the tumor may cause compression of the adrenal cortex producing a picture of Addison's disease.[16] On the other hand, Graham[9] in his review of 207 cases, mentioned four cases which showed evidence of adrenal cortical hyperfunction as manifested by hirsutism, obesity and scanty menses.

16. Neurocutaneous Disorders. There has been noticed some relationship between pheochromocytoma and some neurocutaneous disorders. Five per cent of all cases of pheochromocytoma are associated with Von Recklinghausen's disease[3] and there have been two cases reported associated with Hippel-Lindau disease or angiomatosis retinae et cerebelli.[3] Cases have been also reported associated with tuberous sclerosis and encephalotrigeminal angiomatosis.[3]

17. Heredity. It has also been noted that there may be a familial tendency in pheochromocytoma, the best example of which has been the removal of pheochromocytoma in three siblings at the Mayo Clinic.

Special Diagnostic Procedures

I. Pharmacologic Tests.

These can be subdivided into those which by one form or another are capable of inducing a typical adrenal sympathetic attack with an elevation of the blood pressure and those that have the action of blocking the effect of excessive catecholamine in the blood. The first group is used in those cases with paroxysmal hypertension during the normal period and the latter group is used in those with persistently elevated blood pressure or during an attack with elevated blood pressure.

A. Diagnostic Tests Based on Precipitation of Attacks.

1. Cold Pressor Test. Although this is not a pharmacologic test it is considered here because its effect is similar to that of drugs capable of precipitating an attack. By itself it is of no specific value. Its value when used in conjunction with the histamine test will be discussed next. Cases of pheochromocytoma have a more marked response to histamine than to the cold pressor test while the reverse is true in cases of essential hypertension.

2. Histamine Test. In 1945, Roth and Kvale[21] first introduced this substance as a tentative test for pheochromocytoma. In 1954 Massell and Myers[25] reviewed the test.

The procedure is performed as follows: The patient is kept lying down in a room for 15 minutes or until the blood pressure is stabilized. An intravenous infusion of five per cent glucose in water is started and again the blood pressure is checked repeatedly until stabilized. Histamine 0.025 to 0.05 mgm. is rapidly injected through a three way stopcock attached to the intravenous infusion. The blood pressure is then recorded every 30 seconds for five minutes and then every minute for 15 minutes. A blood pressure rise of 60/30 or above occurring promptly within one to four minutes and returning to preinjection levels in five to 15 minutes or longer constitutes a positive test. Histamine acts by a direct effect on the adrenal medulla to produce epinephrine and not by reflex fall in blood pressure as previously supposed.[25]

The test should be done only on patients with a blood pressure of 150/110 or less.

In reviewing 27 cases since 1949,[25] 21 were positive and five gave false negative results; in one the results were equivocal. Three of the five false negative tests were done improperly, in that the resting blood pressure was very high to start with, the intravenous was given too slowly, or sedation was given prior to the test. There are only two false positive results in the literature and the authors still believe that the patients may have pheochromocytoma which was not found at operation.[25]

While performing the test, benzodioxane to administer intravenously, 15 to 20 mgm., or Regitine® five gm., should be at hand in the event of a marked pressor response.

3. Mecholyl® Test. In 1948, Guaneri and Evans[26] described a new test using Mecholyl® as a test substance. The subcutaneous injection of 10 to 25 mgm. of Mecholyl® produced a marked pressor response. Since 1948 the test has been performed in six cases of proved pheochromocytoma.[25] Two gave false negative results, two positive and two equivocal. The authors[25] make no definite suggestions or recommendations as to the employment of this test.

4. Tetra-ethyl-ammonium Chloride Test. A positive response consists of an immediate elevation of blood pressure which persists for about 15 minutes following the intravenous administration of 100 to 400 mgm. of Etamon.® Of 10 proven cases of pheochromocytoma in which this test has been used since it was introduced by LaDue, Morrison and Pack in 1947, three gave positive response, six gave false negative response and two uninterpretable results.[25] These authors[25] indicate that the test is of no practical value and should not be used.

5. DMPP (1,1-dimethyl-4-Phenylpiperazinium Iodide) Test. In 1953, Page and McCubbin[27] described the pharmacologic properties of DMPP. They concluded that this substance stimulated sympathetic ganglia more powerfully than most other substances. They thought then that this substance could be used, probably better than any other in stimulating adrenal medullary tumors, ensuring a high secretory activity. The hypertensive episode so produced, could then be blocked by one of the blocking substances such as benzodioxane or Regitine®. They performed the test in a sus-

ACHROMYCIN

Tetracycline *Lederle*

in the treatment of

infections in surgery

The prevention and control of cellulitis, abscess formation, and generalized sepsis has become commonplace technique in surgery since ACHROMYCIN has been available. Leading investigators have documented such findings in the literature.

For example, Albertson and Trout[1] have reported successful results with tetracycline (ACHROMYCIN) in diverticulitis, gangrene of the gall bladder, tubo-ovarian abscess, and retropharyngeal abscess. Prigot and his associates[2] used tetracycline in successfully treating patients with subcutaneous abscesses, cellulitis, carbuncles, infected lacerations, and other conditions.

As a prophylactic and as a therapeutic, ACHROMYCIN has shown its great worth to surgeons, as well as to internists, obstetricians, and physicians in every branch of medicine. This modern antibiotic offers rapid diffusion and penetration, quick development of effective blood levels, prompt control over a wide range of organisms, minimal side effects. There are 21 dosage forms to suit every need, every patient, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Broad-range antibiotic action to fight infection; important vitamins to help speed normal recovery. In *dry-filled, sealed* capsules for rapid and complete absorption, elimination of aftertaste.

dry- filled sealed capsules

[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N. Y., 1955, pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

Lederle

LEDERLE LABORATORIES DIVISION

AMERICAN CYANAMID COMPANY

PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

PHOTO DATA: AERIAL CAMERA WITH K-2 FILTER AT DUSK, F.11, 4/100 SEC., FAST PAN FILM



ACHROMYCIN ACHROMYCIN

pected case of pheochromocytoma by giving a dose of 1.0 mgm. intravenously with a marked pressor response, which was then immediately controlled by Benodaine®. After the surgical removal of the pheochromocytoma the test was then negative giving only a very mild pressor response. There is no other report in the literature of the use of this substance as a test agent.

B. Diagnostic Tests by Using Blocking Agents.

1. Benzodioxane Test. This test was introduced by Goldenberg, Snyder, and Aranow in 1947.[28] It acts by blocking the pressor effect of excess amounts of epinephrine and nor-epinephrine in the blood. It should be performed then on patients who originally have an elevated blood pressure. The mechanism of the block and also why patients with essential hypertension may respond with a marked pressor effect is not clearly understood.

The procedure of the test is as follows: The same standards for recording the blood pressure are used as in the histamine test. A five per cent solution of glucose in water is started intravenously and after the blood pressure is stabilized an injection of benzodioxane of 0.25 mgm/kg. of body weight up to a maximum of 20 mgm. total dose is slowly injected over a period of two minutes through a three way stopcock. The blood pressure must be checked every 30 seconds during the injection period and for five minutes thereafter and then every minute for a total of 15 minutes. A drop in blood pressure of 30/30 or more constitutes a positive response.

Sedatives and narcotics should be withheld from patients for at least 24 hours prior to the test period. Patients with uremia also give false positive results.

Of 25 patients with proved pheochromocytoma in whom the test has been used,[25] 15 gave unequivocally positive results, four gave equivocally positive results and three gave false negative results. In the four patients with equivocal results the test was performed properly. They all showed a hypotensive response of 26/38, 40/20, 50/15, and 40/0. As may be noted there was a drop in blood pressure either in the systolic or diastolic phase of 35 mm. of Hg. or more. A response like this should make one suspicious although it is not definitely diagnostic according to the standards. The three false negative results are unexplained. False positive results are rare and when found are equivocal.

Benzodioxane is apt to produce side reactions in patients with essential hypertension which include flushing, palpitations, headache, dizziness, numbness in the extremities and an oppressive feeling in the chest, the most alarming of these is a rapid, progressive rise in blood pressure. Hydergine® should be used as an antidote if this marked pressor effect is encountered. Because of these side effects, benzodioxane should be used only in the hospital and should not be used as an office procedure

2. Regitine® Test. This test is performed in the same manner as the benzodioxane test; however, the injection should be made rapidly and the dose should not exceed 5 mgm. The test is considered positive when a depressor effect of 35/25 or more occurs. It has fewer side effects than benzodioxane and these are usually mild. It can be used with safety as an office procedure. It produces a slight depressor effect but rarely over 35/25 in patients with essential hypertension. False positive results are commoner with this test, especially if patients have been sedated, or are uremic. A positive test should be rechecked with benzodioxane.

3. Dibenamine Test. Spear and Griswold introduced this substance as a diagnostic test for pheochromocytoma in 1948.[4] Seven cases of pheochromocytoma have been tested with this substance with a marked fall in blood pressure, averaging 115/81. It has been found also to cause a marked hypotensive drop in patients with hypertension of an average of 59/38.[29] It is considered inferior to benzodioxane and Regitine® in the diagnosis of pheochromocytoma. It is, however, of much value in the medical treatment of the adrenal sympathetic syndrome for the effect is much longer lasting than that of the two previously mentioned drugs.

II. Chemical Analytical Methods.

1. Increased Urinary Excretion of Nor-Epinephrine and Epinephrine.

In 1951 Von Enler,[30] reported six cases of

pheochromocytoma in which he found a 10 to 50 fold increase in the urinary excretion of nor-epinephrine and epinephrine. After removal of the tumors these findings returned to normal. In 1952, Lund[31] reported findings similar to Von Enler's, and he also found normal amounts in the venous blood and urine of seven patients with essential hypertension.

In 1954, Goldenberg et al.,[32] expanded the knowledge in this subject and introduced a much simpler screening procedure for the detection of increased amounts of these substances in the urine.

The chemical method described by Goldenberg et al.,[32] is given in detail in their paper. In general it consists of a preparation of urinary extracts by absorption on precipitated aluminum hydroxide. This is followed by one of the following tests: (1) bio-assay, (2) paper chromatography, (3) photofluorometric evaluation, or (4) absolute quantitation of epinephrine and nor-epinephrine. They performed the test in 16 cases of pheochromocytoma and found it positive in all, by all four methods except in one in which it was equivocal by bio-assay method.

By using a rapid photofluorometric screening procedure all cases studied have been positive. This procedure, however, is apt to give false positive results as demontrated by five positive tests in 46 cases of essential hypertension; so that if the test is positive, a more specific procedure should then be used to corroborate the diagnosis. False positive results are not described by the use of the other four more specific chemical determinations described above.

2. Urinary Corticoids in Pheochromocytoma. Del Greco et al.,[33] because of recent reports that epinephrine is a physiologic stimulant of adrenocortical secretion by reason of a specific effect on the secretion of ACTH, reviewed or corroborated the following previous findings:

(1) "Adrenalin in large doses to the experimental animal provoked increased cortical secretion by pituitary stimulation but it seemed to be non-specific in human subjects."

(2) "Functioning pheochromocytoma do not exhibit the clinical signs of hypercorticoidism," with very few exceptions.

(3) "Sprague and Mason, (personal communication) found increased output of formaldehydogenic corticoids and 17 ketosteroids in two out of 14 cases of pheochromocytoma."

These authors report three cases of pheochromocytoma with no increase in the urinary excretion of these steroids. They conclude: "Prolonged and severe adreno-medullary hyperfunction does not as such elicit increased activity of the adreno-cortical-pituitary axis."

Treatment of Pheochromocytoma

1. Definitive Treatment.

Definitive treatment of pheochromocytoma consists of surgical extirpation of the tumor. X-ray therapy is only palliative. Until 1951 there was a mortality rate consequent to surgery, of 26.4%. In June 1954, however, Kvale et al.,[24] reported 25 cases studied and treated by them, during the past eight years, 23 of which were operated upon with no operative mortality. Two were not operated upon because the tumors were malignant and inoperable. This marked improvement is attributed, not only to better surgical technics, but mainly to a better understanding of the pathologic physiology of this condition and the availability of new drugs to combat episodse of both hypertensive and hypotensive crises.

It is not our intention to discuss the surgical aspects and the specific procedures in the treatment of this condition. These patients should be operated on with great care and under the supervision of a competent surgical team, each member with a clear understanding of the physiologic changes occurring and able to treat them accordingly. The postoperative course is stormy and often characterized by marked hypotension which may last for several hours or several days and should be treated continuously by the administration of Levophed®, until the blood pressure is maintained at normal levels without the necessity of this drug.

2. Medical Treatment.

Medical treatment, although only palliative, is of great importance for it keeps the patient alive until a definitive surgical procedure is performed. The attacks may be easily controlled by the judicious administration of benzodioxane, Regitine® or dibenamine intravenously, thus preventing a cerebral vascular accident or acute congestive heart failure.

Regitine is now available in oral form for the prevention of the attacks by maintaining higher blood levels than by the intravenous or intramuscular routes and for longer periods of time.

Complications, such as cardiac arrhythmias, congestive heart failure, renal failure, cerebral vascular accidents, etc., should be treated by the currently acceptable means.

Summary and Conclusions

1. Pheochromocytomata are tumors of the chromaffin tissue, the symptom complex of this condition being the result of a hyperepinephremia and nor-epinephremia.

2. The symptoms and signs of this condition are reviewed and the special diagnostic procedures are summarized.

3. The definitive treatment of pheochromocytoma is surgical extirpation of the tumor and this should be performed by a competent medico-surgical team with minute to minute care of the patient. By a better understanding of the pathologic physiology of the condition together with better surgical techniques the operative mortality rate of this condition has been greatly reduced.

4. Being, at the present time, the most common cause of curable hypertension, it is the duty of practicing physicians to suspect pheochromocytoma in any case of hypertension and to perform diagnostic procedures tending to rule out this condition where indicated.

References

1. Frankel, F.: Virchows Arch. of Path. Anat., 103: 244, 1886, cited by 3.
2. Labbe, M.; Tinel, J., and Doumer: Bull. Soc. Med., Paris, 46: 982, 1922, cited by 3.
3. Editorial: Annals of Int. Med., Vol. 39, No. 6, Dec. 1953, pp. 1335-1340.
4. Spear, H. C., and Griswold, C.: The Use of Dibenamine in Pheochromocytoma. N. E. J. M., 239: 736, 1948.
5. Youmans, W. B.: Basic Medical Physiology. The Year Book Publishers, 1953.
6. Pitcairn, D. M., and Youmans, W. B.: The Nature of Pressor Substances in Pheochromocytoma Circulation. 2: 505-11, 1950.
7. Goldenberg, M.; Faber, M.; Alston, E. J., and Chargoff, E. C.: Evidence for the Occurrence of Nor-Epinephrine in the Adrenal Medulla. Science, 109: 534-35, 1949.
8. Halton, Pamela: Nor-Adrenalin in Adrenal Medullary Tumors. Nature, London, 163: 217, 1949.
9. Graham, J. B.: Pheochromocytoma and Hypertension. An Analysis of 207 Cases. Surgery, Gynec. and Obst., 92: 2: 105, 1951.
10. Mimo, A. M.; Bennett, W. A., and Kvale, W.: Pheochromocytoma—A Study of 15 Cases Diagnosed at Autopsy, N. E. J. M., 251: 24, 1954.
11. Stigall, T. G.: Pheochromocytoma. Unpublished. Medical Seminars, L. V. A. H., 1950.
12. Mackeith, R.: Adrenal Sympathetic Syndrome. Chromaffin Tissue Tumor with Paroxysmal Hypertension. British Heart J., 6:1-12, 1944.
13. Soffer, A.: Office Diagnoses of Pheochromocytoma. Post Graduate Med., March 1954, 218-221.
14. Soffer, A.: Regitine and Benodaine in the Diagnoses of Pheochromocytoma, Med. CL. of N. A., March 1954, 375-383.
15. Allen, Edgar V.: The George Brown Memorial Lecture. Circulation, 2: 732, 1950.
16. Henry, M. U.: A Case of Pheochromocytoma without Hypertension. British M. J., 4883: 344, Aug. 7, 1954.
17. Belt, A. E., and Powell, T. O.: Clinical Manifestations of the Chromaffin Cell Tumors Arising from the Suprarenal Gland. Surgery, Gyn. & Obst., 59: 9-24, 1934.
18. Smithwick, R. H.; Greer, W. E. R.; Robertson, C. W., and Wilkins, R. W.: Pheochromocytoma, A Discussion of Symptoms, Signs and Procedures of Diagnostic Value. N. E. J. M., 242: 252, 1950.
19. Hines, E. A. J., and Brown, G. E.: Standard Stimulus for Measuring Vasomotor Reactions: Its Application in Study of Hypertension. Proc. Staff Meeting of Mayo Clinic, 7: 332-335, 1932.
20. Smithwick, R. H.: Surgical Physiology of Hypertension. S. Clin. of N. A., 29: 1699-1730, 1949.
21. Roth, G. M., and Kvale, W. F.: Tentative Test for Pheochromocytoma, Am. J. of Med. Sc., 210: 653-60, 1945.
22. Sayer, W. J.; Moses, M., and Mattingly, T. W.: Pheochromocytoma and the Abnormal EKG. The Am. Heart J., Vol. 28, No. 1, 42-53, 1954.
23. Schwarzhoff, E.: Klinik and Behandlung des Phaeochromocytoma—Langerbchs Arch. U. Dent. Zschr. Chir., 275: 232, 1953. Abstract in Surgery, Gynec. and Obst., 98: 371-372, 1954.
24. Kvale, W. F.; Priestly, J. T., and Roth, G. M.: Pheochromocytoma—Clinical Aspects and Surgical Results. A. M. A. Archives of Surgery, 68: 6: 769-778, June 1954.
25. Massell and Myers: Evaluation of Tests Used in Diagnoses of Pheochromocytoma — Modern Concepts of Cardiovascular Disease. 23: 221-224, Apr. 1954.
26. Guaneri, V., and Evans, J. A.: Pheochromocytoma, Report of a Case with New Diagnostic Test. Am. J. of Med., 4: 806-813, 1948.
27. Page, I. H. and McCubbin, J. W.: Cardiovascular Action of 1, 1 Dimethyl-4-Phenylpipera zinium Iodide (DMPP)—A Ganglion Stimulating Agent Useful in the Diagnoses of Pheochromocytoma. Am J. of Med., 15: 675-682, 1953.
28. Goldenberg, M.; Snyder, C. H., and Aranow, H. Jr.: New Test for Hypertension Due to Circulating Epinephrine. J.A.M.A., 135: 971-976, 1947.
29. Massell and Myers: Evaluation of Tests Used in Diagnoses of Pheochromocytoma—Modern Concepts of Cardiovascular Disease. 23: 225-228, May 1954.
30. Von Enler, U. S.: Increased Urinary Excretion of Nor-Adrenalin and Adrenalin in Cases of Pheochromocytoma. Ann. of Surgery, 134: 929, 1951.
31. Lund, V.: Adrenalin and Nor-Adrenalin in Blood and Urine in Cases of Pheochromocytoma. Scand. J. Clin. and Lab. Invest., 4: 251, 1952.
32. Goldenberg, M.; Serlin, I.; Edwards, T., and Rapport, M. M.: Chemical Screening Method for the Diagnoses of Pheochromocytoma. I. Nor-epinephrine and Epinephrine in Human Urine. 16: 310, 1954, Am. J. Med.
33. Del Greco, F.; Corcoran, A. C., and Page, I. H.: Urinary Corticoids in Pheochromocytoma. The J. of Cl. Endocrinology and Metabolism, 14: 6: 678-679, June 1954.

VIRUS DISEASES AND VACCINES

Wilfrid C. Gettelfinger, M.D.
Louisville

WHAT IS A VIRUS? At present an exact definition cannot be given. Much is known about the nature of viruses, but more remains to be learned. Are they infinitesimally small living organisms or inanimate substances capable of producing disease in a susceptible host? Virus particles show no evidence of respiration or biochemical activity when freed of tissue cells. In vitro they do not manifest the usual characteristics of living matter. Certain plant viruses have been obtained in a crystalline chemical compound and the unusual thing is that these compounds retain their infectious properties. However, it is generally believed that they are the smallest known living organisms.

Viruses do not multiply except within living cells. It is not known how they enter or reproduce within the cell. The size of virus particles varies from about 10 to 300 millimicrons. Those over 200 millimicrons can be demonstrated with the ordinary microscope when properly stained. Smaller ones require the use of the electron microscope. Some have not been seen at all. Those which have been seen vary greatly in shape.

Many hundreds of virus diseases attack man, animals, birds, insects, plants and other living things. These infectious agents have a high degree of specificity for various organisms and for certain cells in the host. For example, the mumps virus is known to multiply only in man, certain species of monkeys and in the duck and chick embryos. The influenza virus, which resembles the one for mumps, attacks not only man, but many other animals.

Diseases of plants caused by viruses are so numerous that books have been written on the subject. In reply to a letter to the Department of Agriculture at the University of Kentucky, inquiring about some of these, W. D. Valleau, plant pathologist, gave the following interesting information. Tobacco is subject to mosaic (numerous strains), cucumber mosaic (about 10 strains), ring spot (many strains), etch (at least three strains), vein banding, plantago mosaic, and streak. Forest trees are killed by virus diseases such as phloem necrosis affecting elms. Fruit trees and vegetables have many such diseases. One can appreciate the tremendous economic implications.

In another personal communication, Robert F. Behlow, D. V. M., Department of Animal Pathology, University of Kentucky, listed 18 virus diseases of domestic animals for which vaccines are available. You may have your dog vaccinated against distemper, rabies, and infectious hepatitis. Chickens can be vaccinated against Newcastle disease, infectious bronchitis, fowl pox, and laryngotracheitis. There are several vaccines for horses, cattle, hogs, sheep, and cats.

According to Rhodes and Van Rooyen in their *Textbook of Virology,* (Williams and Wilkins, second edition, 1953), man may have the following virus diseases:

Virus Diseases of Man Grouped According to Tissue Affected and Clinicopathologic Features

Diseases of the Skin or Mucous Membranes

Contagious pustular dermatitis (of sheep)
Cowpox
Foot and Mouth Disease
Herpangina
Herpes simplex (herpes febrilis)
Herpes zoster (shingles, zona)
Molluscum contagiosum
Warts (verrucae)

Exanthemata

Alastrim (variola minor)
Chickenpox (varicella)
German measles (rubella)
Kaposi's varicelliform dermatitis
Measles (morbilli)
Smallpox (variola major)

Respiratory Diseases

Common Cold
Epidemic influenza
Mumps
Ornithosis
Pandemic influenza
Pneumonitis
Primary atypical pneumonia
Psittacosis

Diseases of Genito-Urinary System

Herpes
Inclusion cervicitis and urethritis
Lymphogranuloma venereum (LGV)

Eye Diseases

Epidemic keratoconjunctivitis
Inclusion conjunctivitis
Newcastle virus conjunctivitis
Trachoma

Pyrexias of Virus Origin
Spread by Arthropods

Bunyamwera infection
Bwamba fever
Colorado tick fever
Dengue
Mengo infection
Rift Valley fever
Sandfly fever
Semliki Forest infection
West Nile infection
Yellow fever

Liver Diseases

Infectious hepatitis
Serum jaundice

Generalized Infections

Coxsackie disease
Encephalomyocarditis infection

Neurotropic Virus Diseases

Acute anterior poliomyelitis
Acute lymphocytic choriomeningitis
Australian X disease
Demyelinating encephalitis complicating virus infections, e.g., vaccinia, measles, mumps, varicella, variola
Encephalitis lethargica
Louping ill
North American equine encephalomyelitis
Pseudorabies
Rabies
Russian spring summer encephalitis
St. Louis encephalitis
Venezuelan equine encephalomyelitis
Virus "B"

In reply to a letter to the Kentucky Department of Health, Catherine V. Lawrence, Division of Statistical Services, gave the information below on the number of reported cases and deaths attributable to viruses for the year 1954 in Kentucky.

Number of Deaths and Reported Cases from Diseases Attributable to Viruses, Kentucky, 1954

Cause	Disease	Resident Deaths	Reported Cases
	Diseases Attributable To Viruses		
080	Acute poliomyelitis	42	823
081	Late effects of acute poliomyelitis	3	*
082	Acute infectious encephalitis	10	20
083	Late effects of acute infectious encephalitis	1	*
084	Smallpox	—	—
085	Measles	26	20,754
086	Rubella (German measles)	1	1,427
087	Chickenpox	1	3,505
088	Herpes zoster	4	*
089	Mumps	1	4,725
090	Dengue	—	—
091	Yellow fever	—	—
092	Infectious hepatitis	22	1,004
093	Glandular fever	—	21
094	Rabies	—	—
095	Trachoma	—	1
096	Other diseases attributable to viruses	6	*
480-483	Influenza	92	4,844
492	Primary atypical pneumonia	50	(151)**

* Not reported

** Includes virus pneumonia and pneumonia other than broncho and lobar

There is no satisfactory treatment for most virus diseases. Smaller viruses have not yielded to sulfonamides and antibiotics. Broad spectrum antibiotics are effective in lymphogranuloma venereum, psittacosis, trachoma, inclusion conjunctivitis and the rickettsial diseases. The latter are not considered true viruses. The former are the so-called large viruses. These antibiotics are not effective against other virus diseases.

Immunity to a virus disease may be transient (upper respiratory diseases) or permanent (measles). Subclinical infection is believed to produce immunity in such diseases as poliomyelitis, mumps, yellow fever, infectious hepatitis, and others.

Gamma globulin is useful in modification or prevention of measles and has been recommended in the control of infectious hepatitis. It seems to exhibit activity in the prevention of mumps. It has been investigated in the prophylaxis of poliomyelitis.

The Frei skin test antigen is an aid in the diagnosis of lymphogranuloma venereum. A

mumps skin test antigen available is positive in persons immune to this disease.

Vaccines are used to stimulate resistance or immunity. Serum antibodies develop on recovery from virus infections and after the administration of virus vaccines. Several methods can be used for the determination of antibodies. It is not known where virus antibodies are produced in the body.

Public Health Service Publication Number 50, which lists all licensed biological products, including virus vaccines, was sent to me by W. G. Workman M.D., of the National Health Institute in reply to a request for information on the subject. The following virus vaccines are listed: Encephalitis Vaccine (Herpes F strain), Equine Encephalomyelitis Vaccine (Eastern and Western), Influenza Virus Vaccine, Mumps Vaccine, Poliomyelitis Vaccine, Rabies Vaccine, Smallpox Vaccine, and Yellow Fever Vaccine.

The first person vaccinated against a virus disease in the United States was Daniel Oliver Waterhouse, son of Professor Benjamin Waterhouse at the Harvard Medical School. This was in July 1800 against smallpox, with the cowpox virus, discovered and introduced by Jenner. No doubt more people have been vaccinated against smallpox than any other disease. In answer to the question of how effective is smallpox vaccination, I will ask, have you ever seen a case of smallpox?

Smallpox vaccine is grown on the belly of a calf and harvested about five days after inoculation of the animal. It is then processed for use by the medical profession. It is best given intradermally by the multiple pressure method. Immunity develops in about eight days after successful vaccination and lasts five to seven years or longer.

In 1885 Pasteur developed rabies vaccine. The present vaccine is a living attenuated suspension made from the brains of rabbits infected with attenuated (fixed) rabies virus. Treatment consists of giving an injection subcutaneously each day for 14 days. Vaccination failures may occur in face bites, in which the incubation period may be as short as 17 days. A rare but serious complication may be treatment paralysis which is thought to be an allergic demyelinizing encephalitis developing during the second week of treatment.

Yellow fever vaccine was first supplied by the Rockefeller Foundation. During World War II it was given to men in the armed forces. This virus was passed through 53 monkeys, 18 batches of mouse embryos, 58 chicken embryos and 160 incubating eggs thereby becoming greatly attenuated in virulence and safe for human inoculation. It is grown on egg embryos. The vaccine is given subcutaneously, and should be repeated every three years in persons exposed to the danger of yellow fever. In the U. S. Army in 1942 there were more than 10,000 cases of serum jaundice. This resulted when human serum containing the serum jaundice virus was added as a diluent to a batch of the chick embryo media.

Influenza virus vaccine is a mixture of four strains of virus. It is grown on egg embryos and is inactivated by the addition of formalin. It is given subcutaneously in a one-cc does in September or October and repeated in January or February.

Mumps vaccine is prepared from virus grown on the allantoic fluid of egg embryos. Immunization before adolescence is not recommended because the immunity may wane and permit infection at an older age when there is greater danger of complications. It is desirable not to have mumps after adolescence because of the complications. In susceptible individuals in this group, two subcutaneous injections of one-cc each are given, five to 10 days apart. Booster doses should be given with waning immunity or after exposure to infection.

Equine encephalomyelitis (North American) vaccine is derived from chick embryos, made inactive with formalin and given subcutaneously.

Encephalitis vaccine (Herpes F strain) is prepared from a 10 per cent rabbit brain suspension of formalinized virus and has been suggested as an aid in the treatment of acute and chronic stages of this type of encephalitis.

The production of poliomyelitis vaccine is complicated. The virus is grown on cultures of monkey kidney tissue. Three strains of virus are used. They are grown separately and mixed as the last step in the vaccine preparation. After harvesting the virus is inactivated by the addition of formaldehyde solution. Strictest of regulations and procedures are followed to make the vaccine safe, yet potent. It is given in one-cc intramuscular injections. Two doses are given at an interval of four weeks. A third booster dose is given six or more months later.

With this schedule the possibility of lifetime immunity has been suggested. The exact duration is yet to be determined but likely is a matter of years.

Poliomyelitis vaccine was first used in Jefferson County, Kentucky, in the spring of 1954 in second grade children. These children were given a "Polio Pioneer" button and card. The relative success of this adventure was announced with great fanfare on a nationwide closed circuit telecast and by all means of public communication. States were given the opportunity to get the vaccine with funds supplied by the federal government. Kentucky physicians, over some opposition, accepted this proposal! After mass vaccination was well under way it was called to a halt because a telltale number of vaccinated children in some sections of the country had contracted poliomyelitis. It was later announced by those in authority that some lots of vaccine furnished by a certain pharmaceutical firm contained live virus, even though this firm had followed the standards then required. After further delay more rigorous standards were required for the production of the vaccine and it was again released as safe. In this state it has been made public that less than one-third of the vaccine on hand has been used. This seems tragic in view of the great optimism for the safety and effectiveness of the vaccine. This lethargy on the part of the public can be overcome when they are further assured of the safety of the vaccine; they are better informed as to its availability; a better method of distribution is used; and surely when the next epidemic of poliomyelitis occurs, the latter being a tragic and useless reminder.

Virus work is likely to make big news in medical research in 1956. A few viruses have a special liking for living cancer cells. Research is being done to determine whether these can be used to destroy cancer cells. Some clues suggest viruses as a cause of cancer. Investigation and testing is going on for vaccines which promise substantial protection against some of the many viruses producing common respiratory infections. An effective vaccine against the common cold would be hailed as a Godsend by the average man. Possibly a better poliomyelitis vaccine using live attenuated viruses will be developed. Work is continuing on this. New viruses and new virus diseases will no doubt be discovered. Many more virus vaccines and improvement in present ones seems sure to be big news in 1956 and the future.

TREATMENT OF CHRONIC VENOUS INSUFFICIENCY*

BERT SELIGMAN, M. D.
Toledo, Ohio

Chronic venous insufficiency occurs due to incompetence of the valves of either the deep, superficial, or perforating veins, of all three systems, or any combination of the three. It may occur as a sequel to iliofemoral thrombophlebitis or as a consequence of long standing varicose veins. Without a history of previous deep venous thrombosis the condition has been called venous stasis, and when a history indicates it's thrombosis then the term employed to describe the process is post phlebitic syndrome. The stasis or stagnation of venous blood with retrograde flow results in edema, pain, primary or secondary varicosities, cellulitis, fibrosis, lymphangitis, induration, pigmentation, eczema, dermatitis and ulceration.

*Read before a meeting of the Kentucky Chapter of the American Academy of General Practice.

Causes

Thrombophlebitis indicates the presence of an inflammatory process, which usually first manifests itself in the endothelium of the vein, occurring as an infectious process by extension from the perivenous lymphatics[1] with bacterial invasion or sensitization to toxins, or as a sterile reaction contingent upon chemical or traumatic stimuli. The risk to life because of embolization to the lung is not nearly so great here, though occasionally a proximal coagulation type thrombus may occur which could result in a small embolus of non-lethal type being produced. Suppurative thrombophlebitis with general body spread of septic emboli can occur and here death would not be due so much to the emboli, which are usually very small, but rather to the infectious process which could conceivably be seeded throughout

the body with resultant profound toxemia. The liability here is not so much to life as to limb since varying degrees of damage to the veins and lymphatics produce the varying shades of the post phlebitic syndrome.

Phlebothrombosis occurs as a bland type of venous thrombosis, in which there is no primary inflammatory element, but later secondary infectious component may appear. Paterson and McLachlin[2] have demonstrated that venous stasis is the major factor, with vein wall alteration and abnormalities in blood coagulation not so important in the etiology of phlebothrombosis. Here death may occur as the result of the massive clot breaking loose from its tenuous attachment to a leg vein and being transported to the pulmonary arteries via the right heart. As to the ultimate fate of the limb, less definitiveness and more conjecture is in order. Anticoagulant therapy, proximal vein interruptions, and the occasional conversion of phlebothrombosis into thrombophlebitis, after active therapy has been initiated, all tend to introduce imponderables that alter the ultimate physiologic restoration.

Varicose veins occur for many and varied reasons. There is an hereditary tendency, an association with pregnancy, occupational factors, arteriovenous fistulae, obesity and even an endocrine relationship postulated for the appearance of primary varicose veins. Secondary varicosities manifesting themselves after an iliofemoral thrombophlebitis represent a physiologic adjustment on the part of the great and small saphenous systems to facilitate the venous return. Normally the deep venous circulation returns 80 to 90 per cent of the blood from an extremity to the pelvis. With the deep system blocked out, the superficial veins must of necessity dilate to accommodate the diverted venous stream. Whether varicose veins predispose to superficial thrombophlebitis, or the latter produce varicosities by causing dilatation, tortuosity, thinning of the vein wall and valvular incompetency and inefficiency, is still a moot question. Suffice to say that dilation of the veins does produce relative insufficiency of the valves, and eventually the valves in the communicating veins suffer as well. Thus, whether an iliofemoral thrombophlebitis leads to impaired function of the valves of the comunicating veins, or a long standing varicose vein condition is the cause and effect mechanism, the resulting chronic venous insufficiency presents itself. To add further woe to the problem the injudicious injections of sclerosing solutions, inadequate ligation, ligation with retrograde injections, and anatomical errors at surgery all contribute to the pathology of chronic venous insufficiency.

The treatment of chronic venous insufficiency, whether due to phlebitis or varicose veins has fallen into two main categories. In addition to the use of a four inch Ace bandage reinforced with rubber from the toes to the knee crease or the thigh as indicated, to control the orthostatic edema, the patient sleeps in a bed elevated at the foot on books, bricks or blocks three inches. If dermatitis is present olive oil and zinc ointment is applied and ulcers are controlled with streptomycin compresses. Once the mixed infection present in the ulcer is reduced to a minimum, boric acid or neomycin ointment is applied in a very thin layer. The length of time necessary to prepare a patient for surgery is of necessity dependent upon the subsidence of the edema, the dermatitis, and partial or complete healing of the ulcer. A complete ligation and stripping of the great and small saphenous systems, as indicated, is then carried out, with interruption of the perforating veins previously mapped out. The therapy outlined is common to the two categories herein reported, with deep vein interruption being done as an added procedure in the first group, and a "Cockett" incision the added feature in the second. By way of explanation a "Cockett" incision is made posterior to the medial malleolus in a line which corresponds to the course of the posterior tibial vein, extends from the skin to the deep fascia, and from just below the medial malleolus to the junction of the lower and middle third of the leg.[3] Through this incision the perforating veins, through which the subcutaneous veins of this area drain into the deep veins of the leg, can be visualized, ligated and divided, and reflux prevented.

Case Reports

There were 32 patients, 17 females, 15 males, treated in group one with a ligation and stripping of the great and small saphenous systems, and a ligation and division of the superficial femoral vein just distal to the profunda femoris vein. The oldest patient was 72

years old, the youngest was 34, with five in the 30-39 age group, six in the 40-49, 13 in the 50-59, six in the 60-69 and two in the 70-79 group. Twenty patients had a previous history of phlebitis, 12 had varicose veins, with all 32 having pedal and leg edema, and calf pain. Symptoms were present on an average of 12.5 years, with one year being the shortest time interval, and 35 years being the longest. Twenty-four patients had leg ulcers, with bilateral involvement in two, and eight patients did not have an ulcer. Following surgery a 36 month follow up revealed 24 patients classified as good, with complete healing of the ulcer (if one had been present), no recurrence of varicosities, subsidence of pain, cellulitis, eczema, dermatitis and lymphangitis, lessening of the fibrosis and induration, and diminution in the extent of the edema. Of the eight patients with a bad result five had had ulceration prior to surgery, and despite intermittent healing when seen 36 months post operatively the ulcer was present again. Three patients did not have an ulcer prior to surgery, did not have an ulcer in follow up, but the leg was essentially unchanged. All three sustained a deep venous thrombosis within seven days of the surgery as manifested by fever, pain and massive swelling. This acute process was treated with anticoagulants, anti-biotics, leg elevation, leg compression with a four inch Ace bandage and active ambulation commensurate with the patient's general condition.

There were 41 patients in the second group, 29 females, 12 males, with the great and small saphenous systems being subjected to ligation and stripping and a Cockett incision. The oldest patient was 65, the youngest 25, with four in the 20-29 group, 13 in the 30-39,12 in the 40-49, eight in the 50-59 and four in the 60-69 group. The shortest time interval of symptoms was one year, the greatest 45 years, with an average of 12.9 years. There were 13 patients with a previous phlebitis, 28 with varicose veins, with 21 having leg ulcers, with bilateral involvement in two, and 20 without leg ulcers. Follow up studies on this group range from four to 25 months with all patients' response to surgery classified as good. All ulcers have healed, pain is gone, dermatitis, eczema, cellulitis and lymphangitis have subsided, the previous fibrosis and induration is lessened, varicosities have not recurred and the edema has decreased.

All results in this study are reported as either good or bad. The terms are self explanatory, and euphemisms are not necessary. All patients in the Cockett treated group, when seen in follow up, were good. This does not imply that the leg has been restored to the state it was in before chronic venous insufficiency occurred. Restoration of normal physiology is impossible, but sufficient amelioration of the pathologic physiology is achieved that patients' activities in their day to day existence approach a normal pattern. Ulcers have healed, without recurrence, all the signs and symptoms that stigmatize this condition abate with one exception—edema. Edema, as a consequence of therapy, can be diminished in amount, but can never be completely nor permanently gotten rid of. The most outstanding difference, and there are several, between the Cockett treated patients, and those subjected to superficial femoral vein division, is that the latter group have a more intractable type of edema. In addition to this defect deep venous thrombosis has occurred in three patients following division of the superficial femoral vein, thereby worsening the previously present edema. In dissecting the superficial femoral vein preparatory to division collaterals are sacrificed and lymphatics disturbed, so that venous return not only is unimproved following this type of surgery, but in some instances is further impeded. The eight bad results attest to this. Activity which requires immobilization as washing or ironing clothes, standing for long periods of time as a bank teller, elevator operator or a dentist or any circumstance wherein leg motion is markedly restricted will of necessity have to have compression to fit the occasion. The type of compression usually used is a four inch Ace bandage reinforced with rubber, with the superficial femoral group employing it more persistently than the Cockett group. The skin in both groups following surgery while not what it was before chronic venous insufficiency occurred does exhibit changes in texture, color, mobility and overall appearance indicative of a healthier situation less susceptible to trauma with the Cockett group definitely more improved.

Massell and Kraus[4] demonstrated by phlebography that recanalization occurs in veins

previously obstructed by a thrombophlebitic process thereby indicating that the thrombotic obstruction was not permanent. As a consequence varicose veins occurring secondary to a deep venous thrombosis could be extirpated without sacrificing important collateral channels.

Shumacker, Moore and Campbell[5] concluded from their venographic studies that regurgitation occurs in normal and abnormal femoral veins during quiet dependency, and following exercise radiopaque material cleared from these same veins. Thus the central movement of blood to the heart was facilitated by veins whose valvular efficiency left something to be desired. Ligation and division of these deep veins is not only not indicated, but Boyd, Catchpole, Jepson and Rose[6] reviewed 42 patients clinically, with venous pressure studies and by phlebogram and decided it was ineffective and based on faulty reasoning. Venous pressure determinations by Ochsner and his group[7] indicate a similar conclusion that it is injudicious to ligate either the superficial femoral or popliteal vein in the postphlebitic syndrome patient.

Despite the controversial thinking still rampant as to what constitutes the ideal treatment for chronic venous insufficiency, whether engendered by venous stasis secondary to long standing varicose veins or secondary to an iliofemoral thrombophlebitis which has faded into the postphlebitic syndrome, major venous ligation is no longer considered the sine qua non in the overall treatment program[8]. Some patients have improved as a result of having the superficial femoral or popliteal veins ligated and divided, together with an adequate ligation and stripping of the great and small saphenous systems. On the other hand, in those patients where the major venous ligation was omitted, and where the great and small saphenous veins were ligated and stripped together with a Cockett incision, the improvement was greater, more sustained and was the rule rather than the exception.

Conclusions

1. Chronic venous insufficiency may occur secondary to iliofemoral thrombophlebitis or long standing varicose veins.

2. Superficial femoral vein interruption combined with great and small saphenous vein ligation and stripping yielded 24 good and eight bad results.

3. Ligation and stripping of the great and small saphenous systems plus a Cockett incision gave 41 good and no bad results.

4. While improvement was evident in both groups, it was greater, more sustained and the rule rather than the exception in the Cockett group.

5. Ligation of a major vein hinders the central movement of blood, regardless of valvular insufficiency, and therefore should not be done.

References

1. Ochsner, A. Venous Thrombosis. J.A.M.A., 132:827-833, 1946.

2. Paterson, J. C., and McLachlin, J. Precipitating Factors in Venous Thrombosis. S. G. & O., 98:96-102, 1954.

3. Cockett, F. B., and Jones, D. E. E., The Ankle Blow-Out Syndrome. The Lancet, January 3, 1953, p. 17.

4. Massell, T. B., and Kraus, A. R., A Physiological Approach To Peripheral Venous Stasis. Angiology, 1:150-160, 1950.

5. Shumacker, H. B., Jr., Moore, T. C., and Campbell, J. A. Functional Venography of the Lower Extremities. S. G. & O., 98:257-272, 1954.

6. Boyd, A. M., Catchpole, B. N., Jepson, R. P., and Rose, S. S., Major Venous Ligation in the Treatment of Postphlebitic Sequelae. The Lancet, July 18, 1953, p. 113.

7. DeCamp, P. T., Schramel, R. J., Ray, C. J., Feibleman, M. D., Ward, J. A., and Ochsner, A., Ambulatory Venous Pressure Determinations in Postphlebitic and Related Syndromes. Surgery, 29: 1-162, 1951.

8. Seligman, B., The Post Phlebitic Syndrome. Angiology, 2:393-397, 1951.

9. Myers, T. T., and Cooley, J. C., Varicose Vein Surgery in the Management of the Postphlebitic Limb. S. G. & O., 99:733-744, 1954.

CASE DISCUSSIONS

A CASE OF CONVERSION HYSTERIA

THE UNIVERSITY OF LOUISVILLE HOSPITALS
FROM THE LOUISVILLE GENERAL HOSPITAL*

This 14 year old white female was transferred to the psychiatric service of this hospital on April 5, 1956 from the Children's Hospital with a chief complaint that she was unable to walk, or to use her legs in any way.

In August, 1954, the series of happenings began which culminated in her admission to this hospital. At that time, leaving her father and older half brother in Detroit, her mother brought her to Kentucky to visit her maternal grandmother. While there, the patient became rather lethargic and showed decreased energy for some two or three weeks. Returning from a movie she had attended with a group of girls, she suddenly complained of pain in her right side and back. That night she became weak in her legs and by morning was unable to walk. Hospitalized, x-rays showed what might have been an old spinal injury. A month of bed rest was advised with a review at the end of that time. At home, still unable to walk, the month of bed rest was ended. The parents decided to take her to a chiropractor rather than back to the hospital. The chiropractor showed the family x-rays which he said showed the spine to be "at least an inch and a half off". He treated her with "adustments" three times a week for a month. She was then able to walk with crutches, continuing to use them and a cane for some seven months until April, 1955. She then walked, played, and lived in a normal fashion until October, 1955, when at choir practice her legs began to "draw" and "knots would rise up in the muscles of her legs".

She was carried home by choir members, immediately put to bed and, although she was able to walk, the family pridefully stated they "didn't let her feet touch the floor for six weeks." During this time the chiropractic treatments were resumed and she returned to school in December, 1955. She again did well until February 9, 1956 when at school a classmate pulled a chair from under her. She immediately became "paralyzed" in both legs. When returned to chiropractic care, results were not forthcoming. She was moved to another hospital where x-ray and spinal fluid were found to be normal and she was transferred to Kosair Hospital for treatment. There the diagnosis of conversion hysteria was made and she was further transferred to the Children's Hospital for study. At that hospital, the diagnosis was concurred in by the pediatricians, neurologists, and psychiatrists and she was transferred to the psychiatric service of the Louisville General Hospital on a stretcher on April 5, 1956 and discharged, walking, on April 11, 1956 with referral to the Psychiatric Out-Patient Department for follow-up care.

Family history shows both parents to be 45 years old and in good physical health. This is the second marriage of the father, who tends to be rather strict in his dealings with the patient as well as a 16 year old son by his former marriage who has been involved in some delinquency. The mother is the more indulgent of the parents.

Previous history shows, in addition to the usual childhood diseases, an acute febrile episode in 1948 with headache and arthralgia, for which a spinal puncture was done. Although she was up and about in two weeks she complained of severe constant headache for months afterward. In 1952 she had a similar illness with inability to move her legs for two weeks. On this occasion, spinal puncture immediately restored the function to her legs, but she often asked off from school as her "back hurt" or she "had a headache". In 1953 she fell on icy steps and hurt her back". Although there was some pain at the time, it has

*Hospital Case No. LGH 285461.

since become more important in the family as "the time she hurt her back".

She is described as an excellent ninth grade student. She is interested in church, choir and the Girl Scouts. She says she is not interested in boys. She began to menstruate three months before her episode in 1954 and had been prepared for this by her mother.

Mental examination showed her to be a sturdy, well developed, adolescent girl of average intelligence lying quietly in bed, in fair spirits and no distress. She talked readily of her illness with no distortion, bizarreness, confusion, or loss of orientation. She showed little warmth, or spontaneity, and was quite guarded when talking of familial interpersonal relationships.

Physical examination: Pulse 74. Respiration 18. Blood Pressure 112/76. Temperature 98°. The physical examination was within the normal range except for weakness and flaccidity of both lower extremities. Muscle mass and tone were good. All deep tendon reflexes were present and active, with no pathological reflexes found.

All laboratory work, including spinal x-rays were within normal limits except for an electroencephalogram which was read as "moderately dysrhythmic with an irritative focus in the right temporal region". A spinal puncture was not done.

Hospital Course: Upon arrival in this hospital and until studies could be completed the patient was ensconced in bed by her parents and surrounded by books, magazines, fruits, and candies. The next day, after a discussion with the resident psychiatrist as to her ability to walk, she was transferred to an air conditioned, quiet room furnished only with a bed. Here she was quite unhappy, screamed, and cursed for about an hour. She then got on to the floor and continued to express her displeasure at the house staff and nurses. At the end of three hours, she grasped the opportunity to walk out to the recreation area. Although she did require help this very first time, she was able to walk alone throughout the rest of her hospital stay and there was continued improvement in her walking ability. At discharge, six days later, she was referred to the psychiatric out-patient department for treatment of the underlying problems, to prevent a recurrence of the crippling symptoms.

Comments

S. Spafford Ackerly, M. D.: This case is presented not for its unusualness, nor as a diagnostic problem, for by the time it came to the attention of the psychiatrists the diagnosis had been made. Our particular interest is in the treatment, but before we go into that we would appreciate hearing from Dr. Roseman concerning the neurological aspects.

E. Roseman, M. D.: I first saw this patient at the Kosair Hospital on March 10, 1956. Several hours were spent in attempting to obtain a chronologic history from the patient as to the onset of her present difficulties as well as her own and family background. Her story was given literally in the form of an "old wives' tale". I was particularly impressed by her "la belle indifference".

The patient was an adult appearing mature looking young girl who at first glance appeared to be enjoying her illness as long as she was surrounded by her friends, family, books, candies, etc., but who when faced with the "chips being down" so to speak, such as by specific questioning, became somewhat irritated at the examiner.

From a neurophysiological, neuroanatomical standpoint the absence in the history of any sphincter difficulties or any sensory disturbances in an individual with several attacks of paraplegia, some of which were relatively long standing, tend to point away from the possibility of organic factors being present in her illness. This was reinforced further on physical examination by absence of any evidence of any atrophic changes of her lower extremities or sensory disturbances and the absence of any fixed neurologic signs, such as the sign of Babinski, would tend to point against any organic factors being present as an etiologic basis of her illness. I felt this was a hysterical conversion reaction and for this reason suggested that the patient be removed from a predominantly "organic surgically oriented hospital" to a general hospital. It was hoped that there careful psychiatric interview both with the patient and her kinfolks might be carried out with the view in mind not only of caring for the present episode but from the standpoint of prophylaxis of further episodes.

QUESTION: What other type of diagnosis of organic disease should one consider in this patient?

(Continued on Page 546)

SPECIAL ARTICLES

State Hospital and Discharge Procedures

H. L. McPheeters, M. D.

THE KENTUCKY DEPARTMENT of Mental Health recently mailed to every practicing physician in Kentucky a table showing the five admission procedures by which a patient may be admitted to one of the four State hospitals. This table is reproduced here.

There has been some question by the private physicians concerning hospital release procedures. They are as follows:

1. Temporary Visit
   The patient goes home for a short visit (up to 7 days) with every expectation that he will return to the hospital at some specified time.
2. Trial Visit
   The patient leaves the hospital with every expectation that he will make a satisfactory adjustment and remain at home indefinitely. This ordinarily lasts for one year after which the patient is regularly discharged.
3. Discharge
   The patient is discharged completely with no administrative ties to the hospital whatever. This is used when the patient is found to be free of mental disorder or is considered to be so satisfactorily recovered that no follow-up is needed.

It must be remembered that any patient who was admitted on a regular court commitment, must return to the court and petition for restoration of his civil rights after discharge. Otherwise, marriages, divorces, property transactions, etc., will be illegal.

(Continued on Page 547)

PROCEDURES FOR ADMISSIONS TO STATE MENTAL HOSPITALS

KENTUCKY DEPARTMENT OF MENTAL HEALTH

	TYPES OF ADMISSION	ADVANTAGES	DISADVANTAGES
A	VOLUNTARY ADMISSION (Green Form) Patient signs a request for admission stating that he believes he is in need of psychiatric hospitalization. Parents of patients under 21 may sign voluntary requests for minors.	1. Fast and simple 2. No court procedures needed. 3. May go on trial visit or be discharged at any time. 4. No loss of civil rights.	1. Patient may sign out after 5 days notice. 2. Patient may not have insight enough to realize he is ill.
B	MEDICAL CERTIFICATION (Blue Form) Family or friends complete and sign application, and two physicians examine patient and complete certification, stating need for hospital care.	1. Relatively fast and simple. 2. No court procedures needed. 3. No loss of civil rights. 4. May go on trial visit or be discharged at any time	1. Patient may be signed out after 5 days notice, before treatment is completed.
C	HEALTH OFFICER ADMISSION (Pink Form) A licensed Health Officer (M. D.) signs form, requesting immediate hospitalization for 15 days.	1. Fast in emergencies when patient is very disturbed. 2. No court procedure needed. 3. Solves problem when there is no petitioner available. 4. No loss of civil rights.	1. After 15 days patient is discharged or regularly committed. 2. Time is too short for most treatment procedures. 3. No trial or temporary visit is given.
D.	35 DAY OBSERVATION ORDER After petition for a regular committment has been filed, two physicians sign the form, stating the need for immediate hospitalization or that further observation is needed for diagnosis. Then the Circuit or County Judge orders the patient to a hospital for 35 days only.	1. Relatively fast and simple. 2. No loss of civil rights. 3. When presence of illness is in considerable doubt, more study by the hospital is allowed.	1. After 35 days patient is either discharged or regularly committed. 2. Somewhat complicated court action. 3. Time is too short for many treatment procedures. 4. No trial or temporary visit is given.
E	REGULAR COURT COMMITMENT After petition by a relative or friend two court appointed physicians examine the patient and testify before the jury as to whether the patient is mentally ill. If patient is found to be mentally ill, the judge commits him to a hospital.	1. Provides method of compulsory hospitalization. 2. Committee may be appointed. 3. Offers protection of court order if patient or family is inclined to resist hospitalization. 4. Trial or temporary visits are possible.	1. Cumbersome and lengthy. 2. Patient loses all civil rights. 3. Restoration proceedings must be held in court after discharge. 4. Court proceedings may be harmful to a sick patient.



EDITORIALS



What Do Americans Think of the Medical Profession?

Careful diagnosis is as important in achieving good public relations as it is in curing a disease.

If the diagnosis in either case is wrong, the treatment may be wasted. This is true whether it is made solely through general observations by experienced practitioners or with the aid of laboratory procedures.

In 1955 the American Medical Association employed a research firm to conduct a survey of the public's opinion of the medical profession. The survey is an application of PR diagnostic methods comparable to laboratory analyses. The recent release of its findings should be most welcome to all medical societies and physicians.

The study, employing standard sampling techniques, was based on interviews with 3,000 persons in all parts of the nation. Its purpose was to get facts. While interpretations of some of the results may vary, the report provides definite leads for future public relations efforts by the profession.

Persons active in medical public relations have recognized for some time that most people have a high regard for their own physicians, but that many are highly critical of "other doctors" and the profession as a whole. This was definitely confirmed by the AMA study. The extent to which the public differentiates between its own doctor and the profession is shown by summaries of replies to some of the questions.

Sixteen per cent of the people said that it is true or probably true that their own doctor charges too much. Forty-three per cent thought that most doctors charge too much.

Eighteen per cent expressed the opinion that their own doctor doesn't give them as much time as they like contrasted with 60 per cent who made this complaint about most doctors.

Nineteen per cent said it is true or probably true that their own doctor is hard to reach for emergency calls. Fifty-one per cent thought so with regard to most doctors.

Five per cent thought their own doctor might be too quick to recommend an operation. Thirty-one per cent felt this might be true of most doctors.

Fifteen per cent believed their own doctor was not frank enough in talking to patients about their illness. Forty-six per cent made this criticism of most doctors.

Fifteen per cent said it was true or probably true that their own doctor keeps people with appointments waiting too long. Forty-one per cent said most doctors do.

Thirteen per cent said their own doctor makes too much money compared to his patients; 38 per cent levied the charge against most doctors.

There may be some difference of opinion as to whether it is bad or good that 16 per cent of the people think their own doctor charges too much, that 18 per cent feel he doesn't give them enough time, that 19 per cent believe he is hard to reach for emergency calls, and that 15 per cent are of the opinion he keeps patients waiting too long.

Some will claim these results show most people to be reasonably well satisfied. Others will feel that such large percentages are grounds for serious concern. Others will point out that since the specific criticisms were not all made by the same people, the actual percentage of complainants is much higher than any single percentage would indicate.

Be that as it may, an unhealthy PR situation is shown by the fact that on these same points, 43 per cent, 60 per cent, 51 per cent, and 41 per cent of the public, respectively, were critical of the profession as a whole. It should be of concern to every physician.

What is the significance of the sharp distinction the public mind makes between its own physician and the profession?

Apparently a large part of the people think their own doctor is an exception. Since almost every physician is so designated by some people, the public is obviously mistaken. A mistaken view, however, is just as powerful as a correct one.

As some one once said, "the public may be wrong, but if it thinks it's right, it's as good as right."

If this discrepancy between the individual parts and the whole shows anything, it demonstrates that 140,000 doctors of medicine can not bring favorable public relations to the profession by pursuing a course solely intended to create good will for themselves as individuals.

The statement has often been made that if every doctor would engage in good public relations practices, the profession's problem would be solved. Because it ignores the important role of organized activities in fields where the individual cannot perform alone, this view is an oversimplification. For the most part, however, it is probably true.

If it is true, how do we account for the difference in attitude people have toward their doctor and the profession?

It would seem the AMA survey shows the doctors to be doing a good PR job for themselves and a poor one for medicine. Since all doctors stand to gain or lose by the profession's total standing, it is obvious that to the extent this is true we have been short-changing ourselves.

The facts indicate the profession has a job on its hands. One that will require painstaking thought and self-examination by each of us if it is to be done. Certainly it seems clear that individual physicians must give more attention to identification of ourselves with all ethical doctors.

Perhaps we should start by selling our patients on the idea that we *are not exceptions* within the profession; by exercising care that chance remarks do not lower public opinion of other men and women in medicine; by consciously selling not only ourselves but the total profession.

Oral Treatment of Diabetes Mellitus

We are now in the age of "miracle drugs." During the past 10 years many new drugs have been introduced with fanfare in the lay press as miracle cures. Patients proudly announce that they are taking "that new drug" for their pet ailment and doctors are constantly reading non-medical magazines to keep ahead of their patients' request for new miracle cures.

Such a situation is the setting for many disappointments in therapy and uncounted serious side reactions. The drug manufacturers are anxious to get the new product on the market before their competitors. The doctor hastens to prescribe before adequate information is available, or before he has time to acquaint himself with the information that is available. The practitioner, who cannot recall incidents in his practice when untoward results followed a hasty prescription, is fortunate indeed.

The November 6, 1955 JAMA contained abstracts of two reports from Germany about the use of a new orally effective anti-diabetic drug, BZ 55. In the January-February 1956 issue of "Diabetes" an excellent editorial by Arthur R. Colwell appeared. A form letter from one of the American manufacturers of the drug has already been circulated among us, with the announced purpose: "To place the facts in the hands of the medical profession since it will be impossible to keep such information from the lay press much longer." Last week another drug company detail man announced to the profession in Kentucky that his company was making BZ 55.

It is not the purpose of this editorial to discuss the scientific data which has been well presented in the references quoted. Like Will Rogers, "I only know what I read in the papers." However, I would like to inject a note of caution.

There is little doubt that the drug will be beneficial in some cases, but best results are reported in cases which respond to dietary control. BZ 55 has not controlled acidosis in any case, nor has it shown great promise in reducing insulin requirement or tendency toward hypo-glycemia in the so called "brittle diabetes."

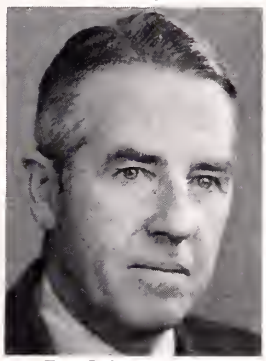
(Continued on Page 547)

ORGANIZATION SECTION

Drs. Bordley, Stephen, Dodd to Speak at Annual Meeting

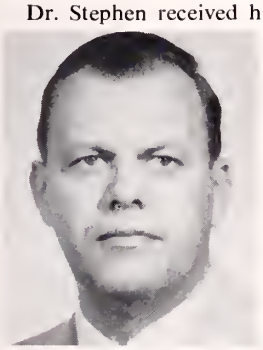
The names of three additional nationally known guest speakers for the 1956 KSMA Annual Meeting were recently announced by Gant Gaither, M. D., Hopkinsville, KSMA President and chairman of the Committee on Scientific Assembly. The physicians are: John Bordley of Johns Hopkins Hospital; C. R. Stephen of Duke University School of Medicine and Katharine Dodd of the University of Arkansas Medical School.

Dr. Bordley, a graduate of Johns Hopkins University School of Medicine, interned at Union Memorial Hospital in Baltimore and served residencies in otolaryngology at Johns Hopkins. Since 1952 he has been otolaryngologist in charge at Johns Hopkins Hospital. He is professor and director of the department of laryngology and otology at the JH School of Medicine.



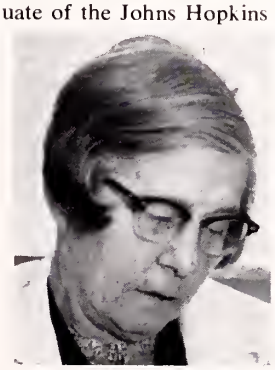
Dr. John Bordley

Dr. Stephen received his medical degree from McGill University in 1940. He is consultant in anesthesia at the Veterans Administration Hospital in Durham, North Carolina. Since 1950 he has been professor of anesthesia at Duke University and University School of Medicine.



Dr. C. R. Stephen

Dr. Dodd is a 1921 graduate of the Johns Hopkins University School of Medicine. In 1925 she became assistant and later associate professor of pediatrics at Vanderbilt. She joined the faculty of the University of Arkansas School of Medicine in 1952 and is now professor and Head of the Department of Pediatrics.



Dr. Katharine Dodd

Annual Meeting Program Released by Committee

The 1956 KSMA Annual Meeting honoring J. A. Hodge, M. D., KSMA President in 1876, will be held September 18-20 at the Columbia Auditorium in Louisville. A tentative program for that meeting follows.

Tuesday, September 18

8:00—10:00	**Refresher Courses—Scientific Movies**
10:00—10:30	**Visit Exhibits**
10.30—10:45	**Formal Opening Ceremonies**
10:45—11:15	**Subject to be announced** I. Frank Tulles, M.D. Head, Department of Medicine University of Tennessee
11:15—11:45	**"Salicylate Poisoning"** Katherine Dodd, M.D. Head, Department of Pediatrics University of Arkansas
11:45—12:00	**President's Address** **Luncheon**
2:00 — 2:30	**"Physiological, Psychological and Social Determinants in the Etiology of Duodenal Ulcer"** I. Arthur Mirsky, M.D. Department of Clinical Science University of Pittsburgh
2:30 — 3:00	**"The Prosthetic Management of Palatal Deficiencies, Congenital and Acquired"** Joseph Bustetter, D.D.S. Kentucky State Dental Association Louisville, Kentucky
3:00 — 3:30	**Visit Exhibits**
3:30 — 4:00	**"Carcinoma of the Colon and Its Early Detection"** Wendell G. Scott, M.D. St. Louis, Missouri
4:00 — 4:30	**"Present Status of Chemotherapy for Tuberculosis"** Paul T. Chapman, M.D. Detroit, Michigan

Wednesday, September 19

8:00—10:00	**Refresher Course—Scientific Movies**
10:00—10:30	**Visit Exhibits**
10:30—11:00	**"Clinical Evaluation of the Rhinotomy Operation"** John E. Bordley, M.D. Johns Hopkins Hospital Baltimore, Maryland

11:00—11:30	**"Treatment of Fractures in Children"** J. Otto Lottes, M.D. St. Louis, Missouri
12:00 — 1:30	**President's Luncheon**
2:00 — 4:30	**Specialty Group Meetings**
Thursday, September 20	
8:00—10:00	**Refresher Course—Scientific Movies**
10:00—10:30	**Visit Exhibits**
10:30—11:00	Speaker and subject to be announced, Kentucky Academy of General Practice
11:00—11:30	**"Early Diagnosis of Carcinoma of the Cervix"** Frank L. McPhail, M.D. Great Falls, Montana
11:30—12:00	**Award Presentations — Inaugural Ceremony, Luncheon**
2:00—2:30	**Subject to be announced** Edgar Burns, M.D. Ochsner Clinic New Orleans, Louisiana
2:30 — 3:00	**"Pitfalls of Pediatric Anesthesia"** C. R. Stephen, M.D. Duke University School of Medicine Durham, North Carolina
3:00 — 3:30	**Visit Exhibits**
3:30 — 5:00	**Panel**

AMA's Outstanding MD of '53, Dr. Greenwell, Dies May 8

Joseph I. Greenwell, M.D., New Haven, American Medical Association's General Practitioner of the Year in 1953, died at a Glasgow Hospital May 8 after suffering a heart attack. He was 82.

Dr. Greenwell was graduated from the Louisville Hospital College of Medicine in 1900. He began his practice in New Haven after graduation and continued that practice for 55 years. In 1953 he was named the KSMA outstanding general practitioner of the year, and later became the only Kentucky physician to receive the coveted AMA award. He was KSMA counselor for 30 years.

An active civic leader, Dr. Greenwell was mayor of New Haven for 14 years and on the town's Board of Trustees for 25 years. He was vice-president of the Bank of New Haven.

A member of St. Catherine's Catholic Church, Dr. Greenwell was a past grand knight of the New Haven Knights of Columbus. He had served as Nelson County Health Officer and as president of the medical staff at Flaget Memorial Hospital and the Nelson County and Muldraugh Hill medical societies.

Dr. Norvell Speaks in Kansas

Wyatt Norvell, M.D., New Castle, chairman of the KSMA Committee on Rural Health, spoke at the 1956 meeting of the Kansas State Medical Society. His talk was entitled "The Art of the Practice of Medicine."



Joseph I. Greenwell, M. D., New Haven, left, shown here receiving the 1953 AMA "Outstanding General Practitioner of the Year" Award from AMA President E. J. McCormick, M. D., died May 9 at a Glasgow hospital. Dr. Greenwell, only Kentucky physician ever to be so honored by the AMA, was 82.

Dr. Toomey Announces Meeting of Sixth District, June 27

The Sixth Councilor District of the Kentucky State Medical Association will meet June 27 at the State Tuberculosis Hospital in Glasgow, according to L. O. Toomey, M. D., Bowling Green, Sixth District councilor.

Registration, fellowship gatherings and tours of the hospital will begin at 4:00 P.M. Russell Starr, M. D., Glasgow is president of the district and Harold Keen, M. D., Bowling Green, is secretary.

C. C. Howard, M. D., chairman of the State Tuberculosis Hospital Commission, will speak at 6:15 p.m. on "Our Service to the Community." Russell Teague, M. D., Louisville, Kentucky Health Commissioner, will make a short talk after Dr. Howard.

The after-dinner session will feature a panel discussion on "Chest Diseases." Dr. Starr will act as moderator. Panel members will be Oren Beatty, M. D., Louisville; Dr. Toomey; W. S. Burton, M. D., Glasgow, medical director and superintendent of the Tuberculosis Hospital; Nathan Lavene, M. D., Louisville and Eugen Puess, M. D., Glasgow.

13 MDs Attend ACP Meeting

Thirteen Kentucky physicians attended the thirty-seventh annual session of the American College of Physicians at Los Angeles, California, April 16-20.

John P. Bell, M.D., and Grover B. Sanders, M.D., both of Louisville, were named junior members of the ACP, according to H. R. Yarp, news editor of the ACP Journal. The Kentucky physicians who attended the meeting were: George N. Burger, Covington; Lt. Col. David L. Deutsch, Fort Knox; John Harvey, and Franklin D. Moosnick, Lexington; and J. Murray Kinsman, Martin H. Boldt, Harold C. Morris, Sam Overstreet, Rebecca Hechter, John S. Llewellyn, Maurice M. Best, Jr., Arthur McCarty, Sr., and Louis Foltz all of Louisville.

KSMA 12th–15th Districts Plan Joint Meeting on June 28

A joint meeting of the 12th and 15th KSMA councilor districts will be held June 28 at Cumberland Falls. The meeting will begin at 4 PM (EST).

Garnett Sweeney, M. D., Liberty, councilor from the 12th district will preside during the afternoon session and Charles Stacy, M. D., Pineville, 15th district councilor will act as presiding officer during the dinner session.

Gant Gaither, M. D., Hopkinsville, KSMA president, will be guest speaker. His talk is entitled "I Dreamed That Greece Might Still Be Free". Four physicians who will present scientific papers have not yet been named. Wives of physicians are invited to attend the meeting.

Third Annual Kenlake Seminar Is Scheduled for July 12

All KSMA members and wives are invited to attend the annual Kenlake Seminar at Kentucky Lake, July 12. The seminar is sponsored by the Kentucky Academy of General Practice and the Tennessee Academy of General Practice.

The program for the meeting, according to Daryl P. Harvey, M. D., Glasgow, is as follows:

12:00 — 2:00	**Registration**
2:00 — 3:00	**"Rheumatoid Arthritis and the Present Status of the Steroid Therapy"** F. Tremaine Billings, Jr., M.D. Vanderbilt University, Nashville, Tennessee
3:00 — 4:00	**"Tidy Obstetrics"** Henry Turner, M.D., University of Tennessee, Memphis, Tennessee
4:00 — 5:00	**"Low Back Pain"** E. G. Grantham, M.D. University of Louisville
6:00 — 7:00	**Dinner** **Fount Richardson, M.D., President of the Arkansas Medical Society, Fayetteville, Arkansas, speaker.**
7:00 — 8:00	**"Diagnosis of the Acute Abdomen"** Allen McAfee, M.D. St. Louis City Hospital, St. Louis, Missouri

Physicians wishing to make reservations for hotel rooms should contact Joseph R. Miller, M. D., Benton, Kentucky.

The Fourth International Congress on Diseases of the Chest of the American College of Chest Physicians will be held in Cologne, Germany, August 19-23. The congress, under the patronage of the Federal Chancellor, Dr. Konrad Adenauer will be attended by representatives from 86 countries. For more information write: Secretary of the Congress; Fourth International Congress of the American College of Chest Physicians, Koln-Deutz, Germany, Messeplatz.

240 Attend Annual Meeting of Fayette Medical Society

Approximately 240 persons from Central and Eastern Kentucky attended the annual dinner meeting of the Fayette County Medical Society on Tuesday, May 15 at the Lafayette Hotel in Lexington.

Robert Berson, M. D., dean of the Medical School of the University of Alabama at Birmingham was the guest speaker for the evening. Dr. Berson's talk was entitled "Obesity and Arteriosclerosis."

John S. Sprague, M. D., Lexington, president of the Fayette County Medical Society, was the presiding officer.

80 Attend UMW Conference At Charleston, May 6

Carl Fortune, M.D., Lexington, chairman of the KSMA's Advisory Committee on UMW Welfare and Retirement Fund, made the report for the Kentucky delegation at the fourth Conference on Medical Care in the Bituminous Coal Mine Area at the Daniel Boone Hotel in Charleston, West Virginia on May 6. Approximately 80 attended the conference which is sponsored by the Committee on Medical Care for Industrial Workers of the councils on Medical Service and Industrial Health of the AMA.

The objective of the meeting, according to Dr. Fortune, is to develop better liaison between state medical associations and fund administrators for the resolution of mutual problems concerning the improvement of medical care in the bituminous coal mine area.

Kentucky physicians representing KSMA were: George Archer, Prestonsburg; Clark Bailey, Harlan; G. F. Brockman, Greenville; Gant Gaither, Hopkinsville; Charles Stacy, Pineville; Richard Slucher, Louisville; C. C. Sparks, Ashland; Loman Trover, Madisonville and Dr. Fortune.

Asa Barnes, M.D., Louisville reported for the Kentucky area medical administrators. Howe Eller, M.D., Louisville is also an area medical administrator.

Physicians from the Fund from Kentucky were: David Greeley, Harlan; Gordon Meade, Williamson, and J. Houston Westover, Whitesburg. Dr. Greenly is chief of clinical services at the Harlan Memorial Hospital and Dr. Meade is clinical services chief at the Williamson hospital.

SMA to Meet in Washington

The Southern Medical Association will hold its Golden Anniversary Meeting in Washington, D.C., November 12-15.

Some of the highlights of the meeting will be a geriatrics symposium, scientific and technical exhibits and more than 20 alumni and fraternity reunions. Reservations should be sent to Housing Bureau, Southern Medical Association, 1616 K Street, N. W., Washington, D.C.

Dr. Massie Named President of Ky. Surgical Society

Francis Massie, M. D., Lexington, secretary of the Kentucky Surgical Society since it was founded, was elected president of the organization at its seventh annual meeting May 19 at French Lick, Indiana. Dr. Massie succeeds W. H. Pennington, M. D., Lexington, who was named to the council.

Other officers elected were: Herman Martin, M. D., Ashland, vice-president and C. Melvin Bernhard, M. D., Louisville, secretary and treasurer.

Seven physicians were elected to membership in the organization, making a total of 125 members in the society—a full membership. They are: Ballard Cassady, Pikeville; Robert English, Henderson; John Hemmer, Louisville; Charles Kissinger, Henderson; Herman R. Moore, Jr., Anchorage; Richard C. Spear, Louisville and Walter Turner, Paducah.

Ralph Bowers, M. D., chief of the Surgical Service at the Veterans Administration Medical Teaching Group Hospital in Memphis, Tennessee, was the guest speaker. The following Kentucky physicians presented papers at the meeting: Eugene Todd, Jr., Lexington; W. Burford Davis, George B. Sanders, Condict Moore, D. P. Hall, Houston W. Shaw, George A. Sehlinger, Alvin Ortner, and Everett G. Grantham, all of Louisville.

The society will hold its eighth annual meeting at the Campbell House in Lexington May 17-18, 1957.

The Industrial Medical Association presented its annual award "for health achievement in industry" to the Pennsylvania Railroad. The railroad improved and expanded its medical department during the past year. The staff now includes 67 full time physicians, more than 400 part time surgeons and 41 registered graduate nurses.

Kentucky Chapter, ACS Elects Dr. Griswold President

R. Arnold Griswold, M. D., Louisville, was elected to succeed W. Vinson Pierce, M. D., Covington, as president of the Kentucky Chapter of the American College of Surgeons at the May 18 meeting at French Lick, Indiana.

J. Farra Van Meter, M. D., Lexington was named vice-president and E. C. Strode, M. D., Lexington, secretary-treasurer. Charles Rutledge, M. D., Hazard, succeeds C. C. Sparks, M. D., Ashland as councilor. Other members of the council are Henry Asman, M. D., Louisville and R. W. Robertson, M. D., Paducah.

Four physicians presented papers at the morning session of the meeting. They were: Charles Higgins, Cleveland, Ohio; Kenneth Johnson, Chicago, Illinois; Douglas Atherton, Louisville and Eugene M. Bricker, M. D., St. Louis, Missouri.

The afternoon session, a symposium on "Surgical Gastroenterology," featured these speakers: Lester Dragstedt, M. D., Chicago; Ralph Bowers, M. D., Memphis and O. H. Beahrs, M. D., Rochester, Minnesota.

R. J. Noer, M. D., Louisville, moderated a panel discussion at the afternoon session. The afternoon speakers served as panelists.

Legal Counsel Attends Meeting

Mr. E. Gaines Davis, Frankfort, KSMA legal counsel, attended an AMA sponsored meeting for attorneys representing medical societies, April 19-20 in Chicago.

The meeting, the first of its kind, was an effort to bring the attorneys together to consider mutual problems, views and experiences.



Gant Gaither, M. D., Hopkinsville, KSMA President, was the guest speaker at the joint meeting of the Campbell-Kenton medical society and the Eighth Councilor District May 3. At the speaker's table were: R. C. Smith, president-elect of the Campbell-Kenton society; Ed Mersh, M. D., Eighth District councilor; Dr. Gaither; John Cassidy, president of Campbell-Kenton society; Morris Garrett, secretary of the society and Marc Reardon, vice-president of the society.

KSMA Ninth Councilor District Sponsors Maysville Seminar

Four Louisville physicians presented papers at the combination Ninth Councilor District meeting and Regional Post-Graduate Seminar May 10 at the Maysville Country Club, according to J. M. Stevenson, M. D., Brooksville, KSMA Councilor from the Ninth District. The Mason County Society was the host.

Gant Gaither, M. D., Hopkinsville, KSMA President, was the dinner speaker. His talk was entitled "Only the Masters Shall Praise Us."

The meeting which was co-sponsored by the University of Louisville School of Medicine and the Kentucky Academy of General Practice featured the following speakers: Arthur M. Schoen, M. D., William A. Brodsky, M. D., Frank M. Gaines, M. D., and Ephraim Roseman, M. D., all professors at the University of Louisville Medical School.

Dr. Stevenson described the program as "excellent."

Four KSMA Councilor Districts Have Meetings During April

Four KSMA councilor districts held annual meetings during April. They were: first at Paducah; second at Owensboro; 13th at Ashland and the 14th at Paintsville.

50 Attend First District Meet

Approximately 50 physicians attended the April 25 meeting of the first councilor district at the Ritz Hotel in Paducah, according to J. Vernon Pace, M. D., KSMA councilor for the First District. McCracken County was the host.

Gant Gaither, M. D., Hopkinsville, KSMA president, and J. P. Sanford, Louisville, executive secretary of the KSMA, were the guest speakers for the evening. Dr. Gaither's talk was entitled "Lochiel," and Mr. Sanford spoke on "Your Headquarters Office and You."

Dr. Greene Speaks at Second

George Green, M. D., Lexington, was the scientific speaker at the second councilor district meeting April 24 at Gabe's Restaurant in Owensboro. He spoke on "Toxemia in Pregnancy." Davis county was the host society.

Gant Gaither, M. D., Hopkinsville, president of the KSMA, gave a talk entitled "Hans, the Blue Eyed Dane." Walter L. O'Nan, M. D., Henderson, is councilor from the district.

13th Meets on April 5

The 13th councilor district meeting held in conjunction with the State Tuberculosis Hospital at Ashland, April 5 featured a morning program on diseases of the chest. According to Charles Johnson, M. D., Russell, councilor from the district the speakers were: Oren Beatty, M. D., Louisville; Albert Dickey, M. D., Madisonville and M. L. White, Jr., M. D., Huntington, West Virginia.

Other physicians who participated in the day long program were Gant Gaither, Hopkinsville, KSMA, President; Alvin Ortner, Laman Gray and Walter S. Coe, all of Louisville.

Johnson County is 14th Host

The Johnson County Medical Society was the host society at the 14th councilor district meeting at the Paintsville Country Club April 19, according to John Archer, M. D., 14th district councilor.

Physicians who presented papers at the meeting were: William Kappes, Louisville; J. M. Emmett, Clifton Forge, Virginia and William Engel, Cleveland, Ohio. Gant Gaither, M. D., Hopkinsville, KSMA president, spoke on "Orvell 1984".

75 Hear Gant Gaither, M.D., at Eighth District Meeting

Approximately 75 physicians attended the joint meeting of the KSMA Eighth Councilor District and the Campbell-Kenton County Medical Society, May 3. The latter group acted as host.

Gant Gaither, M. D., Hopkinsville, President of the KSMA, was the guest speaker for the meeting. His talk was entitled "Hearts of Controversy—Major and Minor."

Dr. Gaither urged the doctors to accept their personal responsibility for economic and political matters. He asked that they keep in close contact with their senators and representatives.

New KSMA Members

The following physicians were recently added to the KSMA membership roster:

Robert L. Davis, M.D., Lexington
William Hall, M.D., Middlesboro
Paul Kappes, M.D., Bellevue
J. S. Krakauer, M.D., Middlesboro
William N. Nash, M.D., Louisville
John W. Pate, M.D., Madisonville
Ralph R. Robinson, M.D., Middlesboro
James E. Shaw, M. D., Shepherdsville
Presley Smith, M.D., Hawesville
Thomas Weldon, M.D., Covington
Edgar Wipperman, M.D., Covington

Blue Cross Enrollment Soars

The Blue Cross recorded its largest enrollment growth since 1950 during 1955, according to a recent Blue Cross news release.

During 1955, 3,726,899 people were enrolled in the hospital prepayment program. The fourth quarter enrollment of 1,150,696 was the second largest in Blue Cross history. Nearly one out of every three persons in the United States today is enrolled in Blue Cross.

E. J. Murray, M.D., Resigns

Edward J. Murray, M.D., Lexington, superintendent of Julius Marks Sanatorium since May 1918, recently announced his resignation because of ill health.

Dr. Murray, who has been superintendent of the sanatorium since less than a year after it was opened will, according to published reports, be succeeded by James T. Gilboy, M.D., of the VA Hospital at Dayton, Ohio.

Advisory Committees Named By TB Hospital Commission

The State Tuberculosis Hospital Commission recently appointed advisory committees for the six district hospitals.

Committee members are:

District 1, Madisonville—M. E. Arnold, M.D., and Mrs. Robert Donaldson, both of Madisonville.

District 2, Louisville—P. J. Murphy, M. D., Lebanon Junction and Mrs. Kittie Baird, Versailles.

District 3, Paris—Mitchell Denham, M.D., Maysville, and Mrs. Jack Brennan and Gault Robertson, M.D., both of Paris.

District 4, Ashland—C. Wayne Franz, M.D., Ashland and Miss Lois Leslie, Greenup.

District 5, London—Carl Norfleet, M.D., Somerset and Mrs. Bryant Oliver.

District 6, Glasgow—Elgin Dunham, M.D., Edmonton and Mrs. Vivian Rousseau, Glasgow.

Members of the TB Commission are: C. C. Howard, M.D., Glasgow, Chairman; V. A. Jackson, M.D., Clinton; Alec Spencer, M.D., West Liberty; Fred T. Moffett, M.D., Frankfort and Russell Teague, M.D., Louisville, ex officio.

WA Sponsors TB Program

Five thousand, two hundred Pike County school children were tested for TB this year as part of an annual program sponsored by the Woman's Auxiliary to the Pike County Medical Society. The program, according to Mrs. F. H. Hodges, president, is an effort "to break the chain which has kept TB active and alive in Pike County."

"This program aimed at teaching parents and possible contacts of children who are not being reached by radio, newspapers, mobile units, and the like is to be highly praised", said Woodford B. Troutman, M.D., KSMA Secretary-Editor pro tem. "Such programs will play a big part in eventually combatting this disease."

Dr. Dyer Speaks at MT Meeting

Robert Dyer, M. D., Louisville, spoke at the annual dinner meeting of the State Society of Medical Technologists which was held in Louisville at the Brown Hotel, April 27-28.

Dr. Dyer spoke on the need for a closer cooperation and understanding between the medical profession and medical technologists.

Law-MD Group Elects Officers

R. Arnold Griswold, M.D., was re-elected chairman of the board of the Louisville Law-Science Foundation on May 3. David Cox, M.D., was re-elected treasurer; Mr. Theodore Wurmser, secretary; and Mr. Robert Sloss, vice-chairman. Appointed to three year terms as directors were Sam Clark, M.D., and G. David McClure, M.D., and Mr. A. Scott Hamilton and Mr. William Loraine Mix.

Two Retired Louisville MDs Receive Achievement Awards

Two retired Louisville physicians received the achievement award of the Alumnae Association of the Woman's College in Philadelphia on June 6. Annie Veech, M. D., and Alice Pickett, M. D., both 1909 graduates of the college, were honored for "outstanding medical and scientific achievement."

Dr. Pickett, 77, who retired in 1952 was head of the obstetrics department at the University of Louisville School of Medicine for 25 years. A native of Shelby County, Dr. Pickett went overseas in 1917 and served as a civilian doctor with the Red Cross during World War I.

Dr. Veech, 85, organized and headed Kentucky's first maternal and child-health program. In 1937 she joined the City Health Department which later became the City-County Board of Health. She resigned in 1949.

Matching Funds Established

The announcement of the establishment of a $10,000,000 program of matching grants to the National Fund for Medical Education was made April 15 by H. Rowan Gaither, Jr., president of the Ford Foundation. The national Fund for Medical Education is the organization which distributes to medical schools funds raised by the American Medical Education Foundation and by contributions from industry and the general public.

The Ford Foundation grants, according to Mr. Gaither, will be made on a matching basis over a five to 10 year period with a maximum grant in any one year limited to $2,000,000. This appropriation is distinct from the Ford $90,000,000 endowment announced in December.

19th Edition, AMA Directory Released to Subscribers

The first copies of the 19th edition of the American Medical Directory were mailed to subscribers the last of May.

The new edition, which lists information on 260,638 physicians in the United States, its dependencies and Canada, contains 3,122 pages. Since the 18th edition in 1950 more than 250,000 changes of addresses have been recorded, 46,348 names have been added and 24,225 have been deleted because of death.

The directory costs $30 a copy. Orders can be made to Philip Mohr, Editor of the Directory, AMA, 535 N. Dearborn Street, Chicago, Illinois.

MD Speaks at P-T Meeting

Frank Falkner, M.D., assistant professor of child health at the University of Louisville School of Medicine, spoke at the 36th Annual Kentucky Congress of Parents and Teachers in Cincinnati, May 1. He said children can be made happier if their mental and physical growths are normal.

IMPORTANT RESEARCH CONTRIBUTION

Searle Introduces:

A Practical New Steroid for Protein Anabolism

Nilevar*

(BRAND OF NORETHANDROLONE)

PROTEOGENIC EFFECTIVENESS • The newest Searle Research development, Nilevar, exerts a potent force in protein anabolism. Yet it is without appreciable androgenic effect (approximately one-sixteenth of that exerted by the androgens).

Investigations with Nilevar show that nitrogen, potassium and phosphorus are retained in ratios indicating protein anabolism. Nilevar is thus the first steroid which is primarily anabolic and which provides a practical means of meeting the numerous demands for protein synthesis.

NILEVAR IS ORALLY EFFECTIVE • Clinical response to Nilevar is characterized not only by protein anabolism but also by an increase in appetite and an improved sense of well-being.

SAFETY AND PRECAUTIONS • Nilevar has an extremely low toxicity. Laboratory animals fail to show toxic effects after six months of continuous administration of high dosages. Nilevar should not be administered to patients with prostatic carcinoma. Nausea or edema may be encountered infrequently.

DOSAGE • The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the daily dose is 1 to 1.5 mg. per kilogram of body weight. Individual dosages depend on need and response to therapy. Nilevar is available in 10 mg. tablets. G. D. Searle & Co., Research in the Service of Medicine.

INDICATIONS:

Nilevar is indicated in the vast area of surgical, traumatic and disease states in which protein anabolism is desirable for hastening recovery. The specific indications are:

1. **Preparation for elective surgery.**
2. **Recovery from surgery.**
3. **Recovery from illness: pneumonia, poliomyelitis and the like.**
4. **Recovery from severe trauma or burns.**
5. **Nutritional care in wasting diseases such as carcinomatosis and tuberculosis.**
6. **Domiciliary care of decubitus ulcers.**
7. **Care of premature infants.**



*Trademark of G. D. Searle & Co.

SEARLE

Dr. Gragg Is Hospital Head

Logan Gragg, Jr., M. D., Lexington, has begun duties as superintendent of Eastern State Hospital. He replaces Charles Feuss, Jr., M. D., who resigned to become medical director of the Milwaukee Hospital for Mental Diseases and chief of psychiatric services at Milwaukee General Hospital.

Dr. Gragg was graduated from the University of Louisville School of Medicine in 1941. He has been clinical director at Eastern State for three years.

Future MDs Hear Lecturer

Lt. Col. Eddy D. Palmer, gastroenterologist at Walter Reed Army Hospital in Washington, D. C., spoke at the recent meeting of the University of Louisville chapter of the Student American Medical Association at General Hospital.

William Vonderhaar, president of the student chapter, presented a plaque to Dr. Palmer, who was the second annual lecturer.

Health Officer Gets State Job

Frederick Eberson, M. D., former health officer for Henderson, Webster and Union counties, became director of preventive medicine at the State Health Department May 15. The position, vacated by U. Pentti Kokko, M.D., was filled temporarily by Paul M. Crawford, M.D., director of tuberculosis control.

MDs to Participate on Panel

Clyde C. Sparks, M. D., Ashland, immediate past president of the Kentucky State Medical Association, moderated a panel discussion at the June 5 meeting of the Kentucky Federation of Women's Clubs in Louisville. Panel members were: Clark Bailey, M. D., Harlan; Garnett Sweeney, M. D., Liberty; Duffy Hancock, M. D., Louisville; and Vinson Pierce, M. D., Covington.

The panel, carrying out the theme of the three day convention, "Things We Do That Keep Us Free," discussed the contribution the medical profession makes to freedom.

Four MDs Are APP Members

Four Kentucky physicians were elected to membership in the American Academy of Pediatrics on April 12, according to W. J. Becker, business manager of the academy.

The physicians were: Earl James Farrell, Jr., Newport; Doane Fischer, Harlan; Walter Arnold Kirchner, Louisville and Hugh Bailey Lynn, Louisville.

Cosmetics Symposium Held

The Committee on Cosmetics sponsored a symposium at the 105th AMA Annual Meeting in Chicago, June 11-15. According to Miss Veronica L. Conley, secretary of the Committee, the symposium was held at 3 PM Wednesday, June 13 in the ballroom of the Knickerbocker Hotel.

the most complete optical service in kentucky

Southern Optical COMPANY

HOME OWNED SINCE 1897

CONTACT LENSES
(Fluidless Lacrilens—Corneal)

ARTIFICIAL EYES
(Custom Plastic—Glass)

4th and Chestnut
334 W. Broadway
LOUISVILLE

GUILD OPTICIANS



Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

C I B A
Summit, N. J.

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

2/2226M

10 UMW Hospitals Dedicated

Seven UMW hospitals in Kentucky were among the 10 dedicated by John L. Lewis, UMW President, at the Beckley Memorial Hospital, Beckley, West Virginia on June 2.

The seven Kentucky hospitals are located in Harlan, Hazard, Pikeville, McDowell, Whitesburg, Middlesboro and South Williamson. The other three are located at Man, West Virginia; Wise, Virginia and Beckley.

Muldraugh MDs Meet April 12

The Muldraugh Hill Medical Society held a meeting Thursday April 12 at the Hardin Memorial Hospital.

According to Joseph C. Ray, M. D., Louisville, secretary, the following physicians presented papers at the meeting: Lt. Col. Walter Lumpkens, M. C., Fort Knox; Willard Litzenberger, M. D., Elizabethtown; Capt. Rudolph Wilhelm, M. C., Fort Knox; Rudy Vogt, M. D., Louisville; Israel Muss, M. D., Louisville and Col. Oswald Jensen, M. C., Fort Knox.

Stumbo Hospital is Closed

The Stumbo Memorial hospital near Lackey was closed April 15, according to C. L. Roach, M. D., formerly of Lackey.

The hospital had been used by Dr. Roach, for clinic purposes since March 15. No bed patients were admitted after this date. Dr. Roach recently began a practice in Seviersville, Tennessee.

JCMS Announces New Plans

The Board of Governors of the Jefferson County Medical Society recently took steps to omit names of pharmacists from prescription blanks and to have no more than two listings of physicians in the yellow pages of the phone book.

The Louisville Retail Druggists Association agreed with the physicians that the printed blanks constituted unfair advertising. On the phone book listing issue—the society decided physicians will be listed only under (1) "Physicians and Surgeons (MD)" and (2) a society approved specialty or group.

Dr. Flexner Receives Award

Dr. Abraham Flexner, 89, formerly of Louisville, was recently awarded the Frank H. Lahey Memorial Award at a dinner marking the beginning of Medical Education Week.

Dr. Flexner, not a doctor of medicine, first gained recognition in 1908 with his study of medical schools. In 1917 Flexner became secretary of the General Education Board of the Rockefeller Foundation. Since 1939, when he retired as director of the Institute for Advanced Studies at Princeton, N. J., he has devoted his time to writing books, chiefly on educational and medical subjects.

Townsend is SB of H Member

Fred S. Townsend, PhG, London, was named pharmacy member of the State Board of Health, March 23 by Governor A. B. Chandler. He succeeds Clarence Davis, PhG of Louisville.

Scholarship Fund to Forgive Loans Under New Set-up

The Board of Trustees of the Rural Kentucky Medical Scholarship Fund recently approved a plan whereby medical students will not have to pay back loans if they practice five years in any of 10 critical Kentucky counties.

The program was made possible by a $50,000 appropriation approved by the General Assembly, according to C. C. Howard, M.D., Glasgow, chairman of the Fund.

Students not wanting to practice in any of the 10 critical counties can still get assistance by the standard policy. They must practice in an approved area for the number of years they received assistance and pay the amount borrowed back plus two per cent interest.

The critical counties are: Powell, Martin, Knott, Rockcastle, Magoffin, Elliott, Knox, Cumberland, Leslie and Breathitt.

WA Head Speaks at Meeting

Mrs. R. Ward Bushart, Fulton, president of the Woman's Auxiliary to the Kentucky State Medical Association, was the guest speaker at a recent dinner meeting of Harlan County physicians and their wives. Mrs. C. Stacey, Pineville, President-elect of the WA to the KSMA was a guest at the dinner dedicated to the observance of Doctor's Day. Mrs. Clark Bailey is president of the Harlan County WA.

Compulsory Insurance Backed

Nelson Cruikshank, head of the AFL-CIO department of social security, testifying before the House Ways and Means Committee on HR 9120, reiterated the organization's support for a program of compulsory health insurance.

HR 9120 provides an extra $3.00 per month of federal money for the care of each adult and $1.50 for each child.

Pa. MD Speaks in Louisville

Henry L. Bockus, M.D., chairman of the department of medicine at the University of Pennsylvania Graduate School of Medicine recently spoke before some 200 Louisville doctors and University of Louisville medical students. His talk was the annual lecture sponsored by Alpha Omega Alpha, medical fraternity. The lecture was given in Rankin Amphitheater at General Hospital.

Aero MDs Meet in Chicago

The Aero Medical Association held its annual convention at the Drake Hotel in Chicago, April 16—18. Among the speakers was Frank B. Berry, M. D., Assistant Secretary of Defense, Health and Medicine.

Three hundred eighty physicians will be drafted into the Navy during July—so said a report from the Defense Department, May 16. This will fill armed forces needs through October.

MD TV Show Begins Sept. 9

Live reports on current developments in medical progress will be featured on "Medical Horizons" television series when it begins its new 39 week run on September 9 over 85 American Broadcasting Company stations.

The show, sponsored by Ciba Pharmaceutical Products and the American Medical Association will keep the same show format but will be seen at 4:30 p.m. (EDT) each Sunday.

News Items

Eugene Parr, M.D., a physician in Berea since 1953, is taking a fellowship in surgery at Mayo Clinic in Rochester, Minnesoto. Dr. Parr, a '52 graduate of the University of Louisville School of Medicine, interned at the Baroness Erlanger Hospital in Chattanooga, Tennessee.

Etta Wright Best, M.D., a pathologist, has become associated with the Good Samaritan Hospital in Lexington. Dr. Best received her medical degree from the University of Louisville School of Medicine in 1949. She interned at Queen's Hospital in Honolulu, Hawaii.

Benjamin Todd, M.D., a '51 graduate of the Medical College of South Carolina, has become associated with the Graves Gilbert Clinic in Bowling Green. Dr. Todd interned and served a residency at the Philadelphia General Hospital.

Richard J. Snyder, M.D., has joined the staff of the UMW Hospital in Hazard. A 1954 graduate of the Wayne University College of Medicine (Michigan), he interned at the USPH Hospital on Statten Island, New York. He also was associated with the USPH Hospital at Manhattan Beach in Brooklyn.

Eugene Carter, Jr., M.D., has joined the staff of the UMW hospital in Hazard. Dr. Carter was graduated from the University of Virginia Department of Medicine in 1940 and interned at the University of Virginia hospital. He had his hospital training at Lahey Hospital and Johns Hopkins Hospital.

Leo Kirch, M.D., a 1939 graduate of the Indiana University School of Medicine, has been appointed on the staff of the UMW Hospital at Harlan. A native of Indiana, Dr. Kirch interned at the Indianapolis General Hospital.

Clifford Best, M.D., has become associated with the Hazard Memorial Hospital. A 1925 graduate of the University of Iowa Medical School, Dr. Best had his hospital training at Letterman General Hosiptal, Mayo Clinic and the Unversity of Michigan.

plateau therapy*...

for hay fever and other allergies



CHLOR-TRIMETON
REPETABS, 8 and 12 mg.

*Because they quickly attain and maintain a prolonged, therapeutic plateau, CHLOR-TRIMETON REPETABS avoid the wave-like levels which may be produced by multiple-release granules or t.i.d. medication ...affording optimal patient comfort.

CHLOR-TRIMETON® Maleate, brand of chlorprophenpyridamine maleate.
REPETABS,® Repeat Action Tablets.

CT-J-768

Charles Roach, M.D., a physician in Lackey since 1954, has started a practice in Seviersville, Tennessee. Dr. Roach was graduated from the University of Louisville School of Medicine in 1951 and served an internship at the St. Joseph's Hospital in Lexington.

Samuel Oscar Hodges, M.D., recently began a practice of medicine in Berea. A 1954 graduate of the University of Louisville School of Medicine, Dr. Hodges interned at the St. Elizabeth Hospital in Dayton, Ohio.

James Freedman, M.D., who recently was associated with the Graves Gilbert Clinic in Bowling Green, has begun a practice in Lexington. Dr. Freedman was graduated from the University of Louisville School of Medicine in 1945.

A. L. Beckett, M.D., a physician at Eastern State Hospital in Lexington, recently announced his retirement. He was graduated from the Hospital College of Medicine in 1907.

Dexter Meyer, M.D., who recently returned from the service, has begun a practice in Covington. Dr. Meyer, a '44 graduate of the University of Louisville School of Medicine, served an internship at the US Naval Hospital in Bethesda, Maryland.

In Memoriam

FRANK O'BRIEN, M.D.
New York
1891-1956

Dr. O'Brien, 65, former director of the Louisville Mental Hygiene Clinic, died March 13 at his home in New York.

Dr. O'Brien was head of the clinic from 1921 to 1931. During that time he was a member of the faculty of the University of Louisville School of Medicine and on the staff of the Norton Memorial Infirmary and the Kosair Crippled Children Hospital.

In 1931 he joined the New York Board of Education. He became associate superintendent of New York schools in 1941.

N. M. GARRETT, M.D.
Brodhead
1870-1956

Dr. Garrett, 85, died of a heart attack at his home March 2.

A practicing physician for 58 years, Dr. Garrett had practiced medicine in Brodhead for 29 years. He was graduated from the Louisville Medical College in 1897.

Dr. Garrett was a deacon in the Brodhead Baptist Church.



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Member of the American Hospital Association and National Association of Private Psychiatric Hospitals

Four modern buildings, separate for men and women Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD,
Hospital Administrator

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M.D., Neuropsychiatrist
Medical Director

T. J. SMITH, M.D., Associate

pronounced

MUSCLE-RELAXING ACTION

Equanil*

MEPROBAMATE

(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

LICENSED UNDER U.S. PATENT NO. 2,724,720

For significant relief in myositis, osteoarthritis, backstrain, and related conditions marked by:

- ***Muscle spasm***
- ***Stiffness and tenderness***
- ***Restriction of motion***
- ***Pain***

As a superior muscle-relaxant, EQUANIL offers predictable action and full effectiveness on oral administration. It does not disturb autonomic function and is relatively free from gastric and other significant side-effects. Its anti-anxiety property provides important correlative value.

Usual dosage: 1 tablet t.i.d. The dose may be adjusted either up or down, according to the clinical response of the patient.

Supplied: Tablets, 400 mg., bottles of 50.

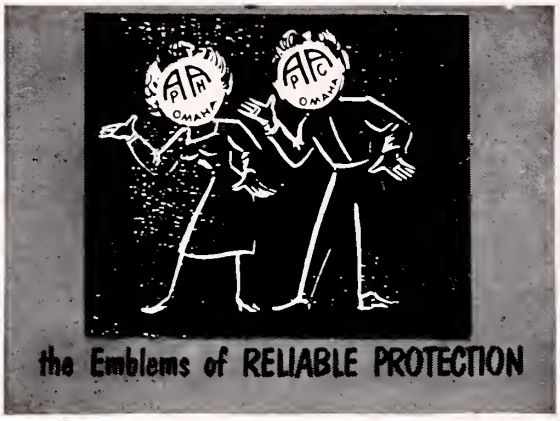
Wyeth®

Philadelphia 1, Pa.

anti-anxiety factor
with muscle-relaxing action
...relieves tension

EMARK

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your eligible dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$23,800,000 PAID FOR BENEFITS SINCE ORGANIZATION

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

Case Discussion

(Continued from Page 529)

Joseph A. Little, M. D.: Although at the time of admission it was rather obvious from our observation of this patient that we were dealing with hysteria, certain organic lesions might be considered. The admitting diagnosis of the resident on pediatrics was hysteria. The possibility of infantile poliomyelitis might be raised. This would affect the muscular activity without any sensory disturbances. However, it was difficult to consider a muscular paralysis without any evidence of muscular atrophy. Spastic diplegia of unknown etiology was also considered. However, we could not elicit any other evidence of a motor neuron disease besides paralysis. Particularly there was no clonus and the response to plantar stimulation was essentially negative. There was some evidence of equal hyperactive tendon reflexes in the lower extremities. However, without sustained clonus this was difficult to be interpreted on an organic basis.

The urinalysis was negative for porphyrins.

QUESTION: In what way did psychiatry help her any more than the chiropractor?

Arthur M. Kasey, M. D.: The only difference up to now has been the time element. Under the chiropractor she was getting lots of attention and sympathy. The secondary gains from illness were quite obvious and she recovered in three months. When she came into the psychiatric service and was treated with "judicial neglect," that is, alone in an air conditioned quiet room, the secondary gains of attention, pity, and sympathy were immediately dispersed. She recovered in three hours. She recovered from the symptoms, but not the underlying personality disorder. Here is the real problem in this girl. To get to the basis of her conflict will take time and effort but it is probably not too profound and by its discovery we should be able to prevent recurrence of her symptoms.

QUESTION: What is being done about it now?

Donald M. Hayes, M. D.: She is currently under treatment by one therapist in the Psychiatric Out-Patient Department, her parents by another. They are all working to improve their relationships with each other.

QUESTION: What about her prognosis?

EVERY WOMAN
WHO SUFFERS
IN THE
MENOPAUSE
DESERVES
"PREMARIN"®

widely used
natural, oral
estrogen

AYERST LABORATORIES
New York, N.Y. • Montreal, Canada
5646

Dr. Ackerly: That will, of course, depend on the efficiency of the treatment. Conversion reactions or hysteria are well known to all of you. The symptoms, in general, mask the real problem, the conflict which the patient cannot solve by direct means so he "converts" this problem to some disability which now demands all his attention and divests him of his worry over the original problem. So, if we simply remove the symptom, as has been done in this case in several different ways, we do not resolve the conflict. Unless this eventually is accomplished, the same or different symptoms will continue to appear, and the patient will not remain "well".

Special Article

(Continued from Page 532)

Any physician in the State may visit a State mental hospital at any time. You will be welcome to look in on any patient you may have sent to a hospital for treatment.

Also, any doctor who wishes an abstract of a patient's record in the hospital to help him with follow-up visits, may obtain the abstract by directing a request to the superintendent of the hospital where the patient was hospitalized.

Editorial

(Continued from Page 530)

No evidence has been submitted that the drug corrects any error in metabolism. It only further alters an already faulty metabolism by adding more variables.

Almost every new patient asks, "Isn't there something I can take instead of shots?" The temptation will be great to yield to the patient's wishes and begin with the new tool when it becomes available for general use.

Few of us can look back to the pre-insulin era, but all of us realize the great change that insulin has brought about. Truly insulin is a "miracle drug." Let us not be too hasty in discarding an old friend for the new without first carefully studying all available information. Above all, let us not encounter the pitfall of substituting "miracle drugs" for careful analysis of each individual and patterning the treatment to fit each individual's needs.

Lewis Dickinson, M. D.

Young Miss Maass bet her life



EVEN at 6:00 A.M., it is warm in Havana. But young Miss Clara Louise Maass felt chilly. Her head ached. Worse, she knew nothing would help.

The illness starts like any other febrile attack. But soon the face is flushed. There is high fever. After two or three days, the pulse becomes feeble, the skin cold and of a lemon-yellow tint. Chances of recovery hardly approximate 50%.

In seven pain-wracked days, yellow fever killed Clara Louise. And it was her own doing.

At Las Animas Hospital, Cuba, in 1901, volunteers were needed for the famous U. S. Army yellow fever experiments.

And she, who had fearlessly nursed the worst fever cases, thought undergoing the disease herself would make her a better nurse. She asked to be bitten by an infected mosquito. "I tried to dissuade her," said the medical director. "But she insisted."

So, in what would soon be America's victorious battle against yellow fever, Clara Louise Maass bravely died as she had lived —for others.

Yet the steel of her quiet, devoted courage still gleams in the strength of today's Americans. For it is still American courage and character that make our country secure —and that actually back our nation's Savings Bonds.

That's why U.S. Savings Bonds are among the world's finest investments. That's why you're wise to buy them regularly, and hold on to them. Start today!



It's actually easy to save money—when you buy Series E Savings Bonds through the automatic Payroll Savings Plan where you work! You just sign an application at your pay office; after that your saving is done *for* you. The Bonds you receive will pay you interest at the rate of 3% per year, compounded semiannually, when held to maturity. And *after* maturity they go on earning 10 years *more*. Join the Plan today. Or invest in Bonds regularly where you bank.

Safe as America — U.S. Savings Bonds

PUBLIC SERVICE ADVERTISING COUNCIL

The U.S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

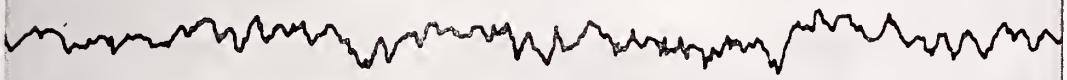
5 1-2 x 8 in. 100 Screen

WHAT IS THE DIFFERENCE BETWEEN A TRANQUILIZER AND A SEDATIVE?

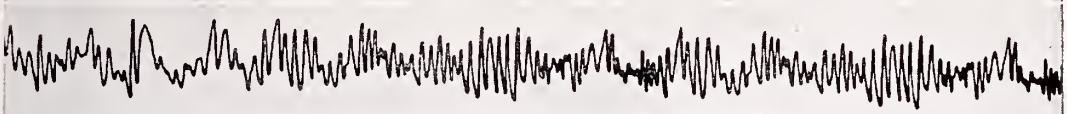
Comparison of the effect of Raudixin (tranquilizer) and a barbiturate (sedative) on the cortical electroencephalogram



No drug.



After Raudixin. E. E. G. not altered.



After barbiturate. Typical "spindling" effect.

Because barbiturates and other sedatives depress the cerebral cortex, the sedation achieved is accompanied by a reduction in mental alertness.

Raudixin acts in the area of the midbrain and diencephalon, and does not depress the cerebral cortex. Consequently, the tranquilizing (ataractic) effect achieved is generally free of loss of alertness.

RAUDIXIN

Squibb Whole Root Rauwolfia Serpentina

DOSAGE: 100 mg. b.i.d. initially; may be adjusted within a range of 50 mg. to 500 mg. daily. Most patients can be adequately maintained on 100 mg. to 200 mg. per day.

SUPPLY: 50 mg. and 100 mg. tablets; bottles of 100, 1000 and 5000.

SQUIBB *Squibb Quality—the Priceless Ingredient*

'RAUDIXIN'® IS A SQUIBB TRADEMARK

"...WHEN CONTINUOUS DIURESIS IS MANDATORY TO CONTROL HEART FAILURE, NEOHYDRIN BECOMES THE SUPERIOR [ORAL] AGENT, SINCE THIS COMPOUND CONTINUES TO PRODUCE DIURESIS WHEN ADMINISTERED DAILY"*

*Moyer, J. H., and Hughes, W. M.:
J. Chron. Dis. 2:678, 1955.

00656

NEW CASTLE SANITARIUM

Telephone 3621
NEW CASTLE, KY.

For the core of
CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the American Hospitol Association
Member af the American Assn. af Nursing Homes
Licensed ond Approved by the State of Kentucky

SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE
PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS
24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES
New Selectemp Modulated Steom Heat With Filtered Air For Maximum Comfort ond Safety
Protected Throughaut With Automotic Fire Detection and Alarm System

IRA O. WALLACE, Administrotor

OCULISTS' PRESCRIPTIONS EXCLUSIVELY
MUTH OPTICAL COMPANY
Prescription Opticians
665 S. 4th Brown Hotel Building Louisville 2

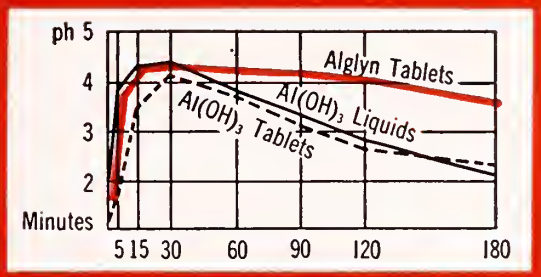
THE KEELEY INSTITUTE
DWIGHT, ILLINOIS
Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Clearview
On The Kratzville Road
EVANSVILLE, IND.

TELEPHONE 5-6181
A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.
SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery
ELECTROENCEPHALOGRAPH — CLINICAL LABORATORY—EKG AND BMR EQUIPMENT—STEREOSCOPIC X-RAY — HYDROTHERAPY.
ALBERT J. CREVELLO, M.D.
Diplomate, American Board of Psychiatry & Neurology, Inc.
MEDICAL DIRECTOR

Announcing Revision of N.N.R. Monograph for



2

ALGLYN®

dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayton PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

Adequate Hospitalization for Treatment of Alcoholics

Doctors find the modern facilities and specialized care available at White Cross Hospital meet a vital need.

Affords Sympathetic Atmosphere, Encouraging Personal Attention, Specially Trained Staff

It is generally believed that alcoholism is self-imposed. Often in general hospitals the alcoholic patient is not considered to be "legitimately" sick, which results in the wrong psychological and emotional atmosphere that aggravates the condition. This is why more and more doctors with alcoholic cases where hospitalization is essential are utilizing the facilities at White Cross Hospital, devoted to the treatment of alcoholics exclusively. Here a sympathetic, comfortable and pleasant atmosphere—so essential to rehabilitation—is assured. The White Cross staff, trained in the special problems of the inebriate, is adequate to assure prompt attention at all hours. The White Cross Hospital is under the direction of a competent licensed physician, with five consulting physicians subject to call. Registered nurses and technicians are in charge 24 hours daily.

Safe, Effective White Cross Treatment

A private hospital offering scientific, institutional, medical, psychological, reflex, reduction and other methods for the rehabilitation of consent patients suffering from alcoholism. With the consent of the doctor and patient, the regular White Cross procedure is followed. At your request, your patient remains entirely under your supervision. You may come and go in White Cross Hospital at will, and will find the staff completely cooperative. Your recommendations will be followed to the letter.

All equipment modern with facilities to take care of 50 patients both male and female.



Salem, Va. Hospital

Approved and licensed by the Virginia State Hospital Board, Member American Hospital Association. Located atop beautiful Mt. Regis, in the quiet serene mountains of Virginia—conducive to rest, comfort and rehabilitation.

For information phone or write for booklet
Rates Reasonable

WHITE CROSS HOSPITAL

Five miles west of Roanoke on route No. 11
Salem, Virginia—Phone Salem 4761

Copyright 1955 H.N. Alford, Atlanta, Ga.

Immediate and Sustained

TRANQUILLITY

NEW

Reserpine c Mebaral®

TABLETS

Each tablet contains:

Reserpine ..... **0.15 mg.** *for hypothalamic action*
Mebaral ..... **30 mg.** *for cortical action*

Indicated in

ANXIETY AND TENSION STATES
PREMENSTRUAL TENSION
MENOPAUSAL SYNDROME
ESSENTIAL HYPERTENSION
ANGINA PECTORIS
CORONARY OCCLUSION

DOSE: 1 tablet 3 times daily. • SUPPLIED: Bottles of 100 tablets.

Relaxation WITHOUT LOSS OF ALERTNESS

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Mebaral (brand of mephobarbital), trademark reg. U. S. Pat. Off.

specify

LEDERLE

POLIOMYELITIS IMMUNE GLOBULIN

(human)

Lederle

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION

AMERICAN Cyanamid COMPANY Pearl River, New York

PATENTED WEDGE GIVES SUPPORT TO CENTER LINE OF BODY WEIGHT ★



★ Insole extension and wedge at inner corner of heel where support is most needed.

- The patented arch support construction is guaranteed not to break down.
- Innersoles guaranteed not to crack or collapse.
- Foot-so-Port lasts designed and the shoe construction engineered with orthopedic advice.
- Conductive Shoes for surgical and operating room personnel. N.B.F.U. specifications.
- We are also the manufacturer of the Gear-Action Shoe designed by noted orthopedic surgeon.
- We make more shoes for polio, club feet and disabled feet than any other shoe manufacturer.

Send for free booklet, "The Preservation of the Function of the Foot Balancing and Synchronizing the Shoe with the Foot."

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

A Division of Musebeck Shoe Company

SECLUSION MATERNITY



FAIRMOUNT HOSPITAL

FOR UNMARRIED GIRLS

Est. 1909

Private sanitarium with certified obstetrician in charge. Folder fully describing services FREE on request. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

Write for Information

MRS. HELEN AMOS

4911 East 27th St.

Kansas City, Mo.

Phone: WA. 3-3577

PLEASE NOTICE

Advertising space in the Kentucky Medical Journal is worth just what you make it. When you buy from firms advertising in the Kentucky Medical Journal, you protect yourself against questionable products and you increase the value of this, your own Journal, to its advertisers. If a product is not advertised in the Kentucky Medical Journal, it may have been declined in order to protect you. Remember this, and use these pages as your buying guide.

WAYSIDE HOSPITAL

168 North Broadway

Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

APPROVED BY AMERICAN MEDICAL ASSOCIATION

STAFF

H. HALBERT LEET, M.D. — JOHN H. ROMPF, M.D.

CARL WIESEL, M.D. — IRVING A. GAIL, M.D.

EDWARD L. HOUCHIN, ADMINISTRATOR

Phone: 2-2050

"...THE MERCURIALS HAVE PROLONGED THE WORKING PERIOD AND LIFE SPAN OF COUNTLESS SUFFERERS FROM CONGESTIVE HEART FAILURE..."*

TABLET
NEOHYDRIN®

*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

00756

THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

unique
in successfully fighting malpractice charges

PROFESSIONAL PROTECTION EXCLUSIVELY SINCE 1899

LOUISVILLE Office
Calvin Bimer, Representative
3119 Hewitt Ave.
Tel. Glendale 8-3060
If no answer, call Clay 3636

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465
334 W. BROADWAY
LOUISVILLE, KENTUCKY

WAbash 6725

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**
( ) **Centralized Bookkeeping** (Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**

THE NEW YORK POLYCLINIC
MEDICAL SCHOOL AND HOSPITAL (Organized 1881)
(The Pioneer Postgraduate Medical Institution in America)

EYE, EAR, NOSE AND THROAT

A nine months combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy; laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology, bacteriology and embryology; physiology; neuro-anesthesia; physical medicine; allergy; examination of patients preoperatively and follow-up post-operatively in the wards and clinics.

PRACTICAL ELECTROCARDIOGRAPHY

A two weeks part time elementary course for the practitioner based upon an understanding of electrophysiologic principles. Standard, unipolar and precordial electrocardiography of the normal heart. Bundle branch block, ventricular hypertrophy, and myocardial infarction considered from clinical as well as electrocardiographic viewpoints. Diagnosis of arrhythmias of clinical significance will be emphasized. Attendance at, and participation in, sessions of actual reading of routine hospital electrocardiograms.

For Information about these and other courses Address:

THE DEAN, 345 WEST 50th St., New York 19, N. Y.

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS—1955-56

Gant Gaither, 109½ East 7th Street, Hopkinsville ..... President
Richard R. Slucher, Buechel ..... President-Elect
Clyde C. Sparks, M.D., Mayo Arcade Ashland ..... Immediate Past President
Everett Baker, 408 Brown Bldg., Louisville ..... Vice-President
N. Lewis Bosworth, M.D., 1701 Fincastle Rd., Lexington ..... Vice-President
Howell J. Davis, 330½ Allen, Owensboro ..... Vice-President
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Secretary-Editor Pro tem
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Treasurer
Charles A. Vance, 271 W. Short Street, Lexington ..... Speaker—House of Delegates
E. W. Jackson, 333 Broadway, Paducah ..... Vice Speaker—House of Delegates
J. Vernon Pace, 709-10 Citizen's Bank Bldg., Paducah ..... Chairman of the Council
Delmas M. Clardy, Hopkinsville ..... Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan	1956
Alternate to be Appointed	1956
W. Vinson Pierce, 33 E. Seventh St., Covington	1957
Leon Higdon, 333 Broadway, Paducah, (Alternate)	1957

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Building, Paducah	1956
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1958
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Carlisle Morse, 3612 Lexington Road, Louisville	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1958
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1957
Ninth District	J. M. Stevenson, Brookville	1958
Tenth District	J. Farra Van Meter, 183 N. Upper Street, Lexington	1958
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1958
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Charles B. Stacy, Pineville	1957

BUYERS GUIDE

JOURNAL OF THE KENTUCKY STATE MEDICAL ASSOCIATION, JUNE, 1956

Ayerst Laboratories 547
Baker Laboratories 492
Brayten Pharmaceutical Co., ... 551
Geo. A. Breon & Co., ... 558
Brown & Williamson Tobacco Co., ... 494
Burroughs Welcome & Company 478
Ciba Pharmaceutical Company 541
City View Sanitarium 488
Clearview Sanitarium 550
The Coca-Cola Company 488
Corn Products Refining Co., ... 482
Fairmount Hospital 554
Foot-So-Port Shoe Co., ... 554
General Elec. Co., X-Ray Dept. 493
The Keeley Institute 550
Lakeside Laboratories 477-550-555
Lederle Laboratories 500-501-554
Eli Lilly & Company 498
W. R. Long (Insurance Co.) 486
Louisville Med. Dental Business Bureau 555
Medical Protective Company 555
Muth Optical Company 550
New Castle Sanitarium 550
N. Y. Polyclinic Med. Sch. & Hosp. 555
Parke, Davis & Company 474-475
Pfizer Laboratories 485-557
Physicians Casualty Ins. Co., ... 546
Pleasant Grove Hospital 544
Riker Laboratories 483
Schering Corporation 496-497-543
Schering Corporation ..... Insert
Clayton L. Scroggins & Associates 489
G. D. Searle & Company 539
Sharp & Dohme 495
Smith, Kline & French 491-560
Southern Optical Company 540
E. R. Squibb & Co., ... 481-549
U. S. Bond 548
Upjohn Company 489
U. S. Vitamin Corp. 559
Wallace Laboratories 479
Wayside Hospital 554
White Cross Hospital 552
Winthrop Laboratories 553
Wyeth, Incorporated 487-545

BETTER

results are obtained with STERANE[1]—3 to 5 times more active than hydrocortisone or cortisone.

BREATHING

capacity is greatly enhanced. "Relief of symptoms is more complete and maintained for longer periods with relatively small doses."[2]

BALANCE

of minerals and fluids usually remains undisturbed. This proves "especially advantageous in those patients with cardiac failure requiring therapy . . ."[3]



in bronchial asthma

Sterane®

brand of prednisolone

Supplied: White, 5 mg. oral tablets, bottles of 20 and 100. Pink, 1 mg. oral tablets, bottles of 100. Both deep-scored.

1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York



save the cigarette for later... Time was you had to wait for a local anesthetic to take hold —you waited, patient waited, nurse waited. **Now, rapid anesthesia....** Blockain* works so fast that clinicians had to describe it as "immediate" and "almost instantaneous." It's practically an understatement to call its action "rapid." **Longer anesthetic duration....** Besides being able to go to work sooner, you can work at an easier pace. Blockain lasts long enough so you can proceed from incision to closure on one injection. You finish up with a neat suture line undistorted by repeated instillations. The patient leaves uncomplaining and comfortable. ☞ *A busy clinician's experience with Blockain in fourteen cases of Colles' fracture:* A single 2-5 cc. injection of Blockain into the hematoma produced anesthesia in an average of 3 minutes 15 seconds. The average duration of these operations, closed reductions, was 25 minutes. Anesthesia persisted beyond the time required for reduction permitting splints to be applied, postreduction X-rays to be taken and the patients sent home feeling comfortable. **BLOCKAIN,** 30 cc., 0.5% (5 mg/cc.). Your office-ideal local anesthetic. For additional information write GEORGE A. **Breon** & COMPANY, 1450 Broadway, New York 18, N. Y.

*BLOCKAIN® BRAND OF PROPOXYCAINE HYDROCHLORIDE BREON.

a great new fortified aqueous vitamin formula

new... provides

growth-promoting vitamin B_{12}

lipotropic choline, betaine, inositol
to aid carbohydrate and fat metabolism

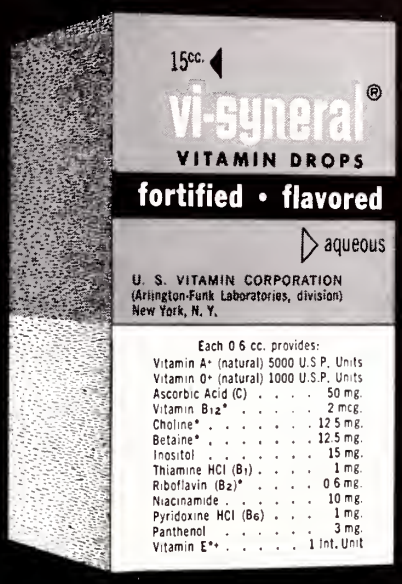
anti-convulsant vitamin B_6
... other essential B-complex factors

vitamin E for muscle tone

100% natural vitamins A and D
—water soluble, better utilized

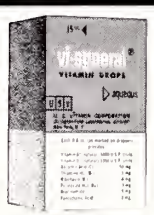
deliciously flavored

no burp, no fish oil taste
or odor — allergens removed



vi-syneral vitamin drops fortified (flavored)

available
as
before



regular
vi-syneral vitamin drops (unflavored)

Samples? write...
u. s. vitamin corporation
(Arlington-Funk Laboratories, division) • 250 East 43rd St. • New York 17, N. Y.

THORAZINE* *can help your patients to endure the suffering caused by*



for example: ***in burns***

Thorazine's unique tranquilizing action can reduce the suffering caused by the pain of severe burns. 'Thorazine' acts, not by eliminating the pain, but by altering the patient's reaction—enabling him to view his pain with what has been described as "serene detachment." Karp et al.,[1] reporting on the use of 'Thorazine' in patients with severe pain, observed that 'Thorazine' produced "a quiet, phlegmatic acceptance of pain."

'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

'Thorazine' is available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

Smith, Kline & French Laboratories, Philadelphia

*T. M. Reg. U. S. Pat. Off. for chlorpromazine, S.K.F.

1. Karp, M., et al.: Am. J. Obst. & Gynec. 69:780 (April) 1955.



THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION

In this issue:

The Disability Freeze
Surgical Treatment of Lymphedema
The Importance of Leukoplakia in Oral Cancer

See Table of Contents Page 564

KSMA
Annual Meeting
Sept. 18-20, 1956

VOLUME 54 • NUMBER 7 • JULY 1956



the logical drug

to use first[1]

for petit mal epilepsy

MILONTIN®

(phensuximide, Parke-Davis)

KAPSEALS® and SUSPENSION

five years of study confirm[2]

- effective in the petit mal triad
- one of the least toxic of all anti-epileptic drugs
- well tolerated

In patients with mixed grand mal—petit mal epilepsy, drug compatibility permits use of MILONTIN with Dilantin® Sodium (diphenylhydantoin sodium, Parke-Davis) or with Dilantin Sodium with Phenobarbital.

MILONTIN Kapseals, 0.5 Gm., bottles of 100 and 1,000; also available as MILONTIN Suspension (250 mg. per 4 cc.) in 16-ounce bottles.
Detailed information upon request, or from your Parke-Davis representative.

1. Davidson, D. T., Jr.; Lombroso, C., & Markham, C. H.: *New England J. Med.* 253:173, 1955.
2. Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955.

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

60028

The JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR PRO TEM: W. B. TROUTMAN, M. D. MED. EDITORIAL EDITOR: S. A. OVERSTREET, M. D.
MANAGING EDITOR: J. P. SANFORD BOOK REVIEW EDITOR: WALTER S. COE, M. D.
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D. ORGANIZATION EDITOR: BARBARA N. MORGAN
CASE DISCUSSIONS EDITOR: J. C. BELL, M. D. PRINTERS: GIBBS-INMAN, LOUISVILLE

ADVISORY COMMITTEE TO THE EDITOR

Richard J. Rust, M. D. Guy Aud, M. D., Chairman James E. Hix, M. D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1958	Term Expires July 1, 1957	Term Expires July 1, 1956
Henry B. Asman, M.D.	Carey C. Barrett, M.D.	Everett H. Baker, M.D.
Richard Elliott, M.D.	Joe Bush, M.D.	John L. Dixon, M.D.
Rankin Blount, M.D.	Allen E. Grimes, M.D.	George G. Greene, M.D.
Marion F. Beard, M.D.	Richard F. Grise, M.D.	R. Arnold Griswold, M.D.
Glenn Bryant, M.D.	Billy Keller, M.D.	O. Leon Higdon, M. D.
Douglas Scott, M.D.	A. J. Miller, M.D.	James M. Keeton, M.D.
William C. Buschemeyer, M.D.	Robert Reeves, M.D.	Frank Moore, M.D.
Harry D. Abell, M.D.	Charles R. Yancey, M.D.	Alvin C. Poweleit, M.D.

Published at 620 S. Third Street, Louisville 2, Kentucky

Subscription $8.00 per year Single Copy .80

Contents

SCIENTIFIC ARTICLES

CHLORPROMAZINE IN A STATE HOSPITAL, Logan Gragg, M.D. 587
SURGICAL TREATMENT OF LYMPHEDEMA, William T. Swartz, M.D. 590
SOME EFFECTS OF GENERAL ANESTHETIC AGENTS ON THE HEART, David Davis, M.D., Kenneth Boniface, M.D., and Charles Whitcher, M.D. 594
A UROLOGIC PERSPECTIVE OF ABDOMINAL TUMORS, Frank M. Woods, M.D. ..598
EVALUATION OF VAGOTOMY AND PYLOROPLASTY IN THE TREATMENT OF DUODENAL ULCER, Howard E. Dorton, M.D. 602
THE RESIDUAL TUBERCULOSIS DISEASE AFTER CHEMOTHERAPY. E. M. Medlar, M.D. 610

EDITORIALS

THE IMPORTANCE OF LEUKOPLAKIA IN ORAL CANCER 617
TRUSTEE-STAFF RELATIONSHIPS 618

SPECIAL ARTICLES

REPORT ON ELEVENTH NATIONAL CONFERENCE ON RURAL HEALTH 615
THE DISABILITY FREEZE 616

ORGANIZATION SECTION

Specialty Groups Name Speakers 619
Nine Ky. MDs Active at AMA Meeting ..619
Better Distribution of MDs is Aim 620
Dr. Allman Is AMA President-elect 621
AMA Delegates Discuss Major Issues 620
Dr. Graves Honored in Chicago 621
118 Ky. MDs Attend AMA Meeting 621
U of L Med School Due $500,000 622
Navy Will Soon Need 380 Doctors 622
$1,061,750 Given 46 Ky. Hospitals 622
Dr. Murray Inaugurated as AMA Head...623
Give MDs Speak to Ky. Women's Group..623

REGULAR DEPARTMENTS

President's Page 568, In the Books 572, Washington News Digest 578, News Items 624, In Memoriams 626, County Society Reports 630

Second Class Mail privileges authorized at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

NOW AVAILABLE....

a new unique antibiotic

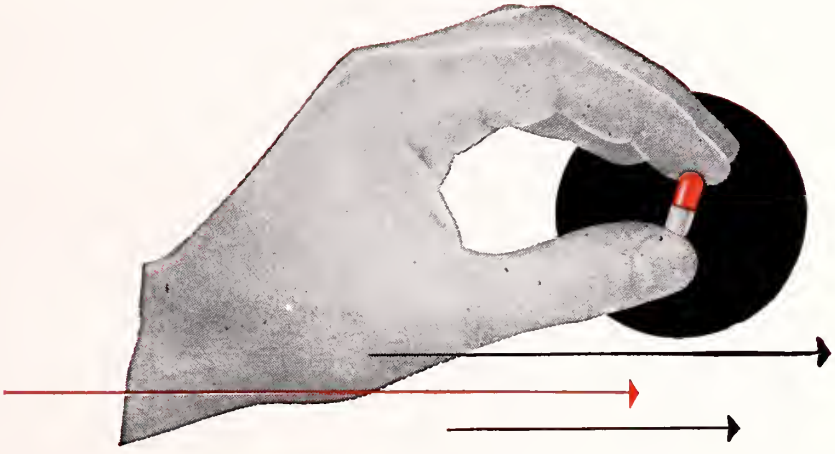
PROVED EFFECTIVE

AGAINST SPECIFIC

ORGANISMS (***staphylococci and proteus***)

RESISTANT TO ALL OTHER

ANTIMICROBIAL AGENTS



to overcome specific infections that do not respond to any other antibiotics[1,2,3]....

New...



TODAY's resistant pathogens are the tough survivors of a dozen widely used antibiotics. Certain organisms, notably *Staphylococcus aureus*[4] and susceptible strains of *Proteus vulgaris* produce infections which have been resistant to *all* clinically useful antibiotics.

To augment your armamentarium against these resistant infections, 'CATHOMYCIN' (Novobiocin, Merck), derived from an organism recently discovered and isolated in the Merck Sharp & Dohme Research Laboratories[1], is now available.

SPECTRUM—'CATHOMYCIN' [1,2,3,5,6] has also been shown to be active against other organisms including—*D. pneumoniae, N. intracellularis, S. pyogenes, S. viridans and H. pertussis*, but clinical evidence must be further evaluated before 'CATHOMYCIN' can be recommended for these pathogens.

ACTION—'CATHOMYCIN' in optimum concentration is bactericidal. Cross-resistance with other antibiotics has not been observed.[7]

TOLERANCE—'CATHOMYCIN' is generally well tolerated by patients. [5,6,8,9,10,11]

'CATHOMYCIN'

(Crystalline Sodium Novobiocin, Merck) **SODIUM**

ABSORPTION—'CATHOMYCIN' is readily absorbed [5,6,9] and oral dosage produces significant blood and tissue levels which persist for at least 12 hours.[7]

INDICATIONS: Clinically 'CATHOMYCIN' has proved effective for cellulitis, carbuncles, skin abscesses, wounds, felons, paronychiae, varicose ulcer, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections caused by susceptible strains of *Proteus vulgaris*.[6,7,8,9,10,11,12,13,14] Also, it is of particular value as an adjunct in surgery since staphylococcic infections seem prone to complicate post-operative courses.

SUPPLIED: 'CATHOMYCIN' Sodium (Crystalline Sodium Novobiocin, Merck) in capsules of 250 mg., bottles of 16.

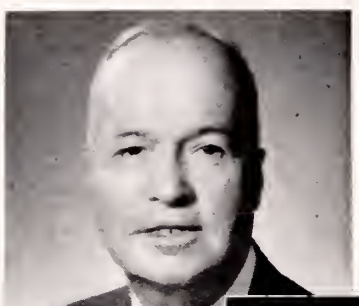
'CATHOMYCIN' is a trademark of Merck & Co., Inc.

REFERENCES:

1. Wallick, H., Harris, D.A., Reagan, M.A., Ruger, M., and Woodruff, H.B., *Antibiotics Annual*, 1955-1956, New York, Medical Encyclopedia, Inc., 1956, pg. 909.
2. Frost, B.M., Valiant, M.E., McClelland, L., Solotorovsky, M., and Cuckler, A.C., *Antibiotics Annual*, 1955-1956, pg. 918.
3. Verwey, W.F., Miller, A.K., and West, M.K., *Antibiotics Annual*, 1955-1956, pg. 924.
4. Kempe, C.H., *Calif. Med.*, 84:242, April 1956.
5. Simon, H.J., McCune, R.M., Dineen, P.A.P., Rogers, D.E., *Antib. Med.*, 2:205, April 1956.
6. Lubash, G., Van Der Meulen, J., Berntsen, C., Jr., Tompsett, R., *Antib. Med.*, 2:233, April 1956.
7. Lin, K.-E., Coriell, L.L., *Antib. Med.*, 2:268, April 1956.
8. Limson, B.M., Romansky, N.J., *Antib. Med.*, 2:277, April 1956.
9. Morton, R.F., Prigot, A., Maynard, A. de L., *Antib. Med.*, 2:282, April 1956.
10. Nichols, R.L., Finland, M., *Antib. Med.*, 2:241, April 1956.
11. Mullins, J.F., Wilson, C.J., *Antib. Med.*, 2:201, April 1956.
12. David, N.A., Burgner, P.R., *Antib. Med.*, 2:219, April 1956.
13. Marton, W.J., Heilman, F.R., Nichols, D.R., Wellman, W.E., and Geraci, J.E., *Antib. Med.*, 2:258, April 1956.
14. Milberg, M.B., Schwartz, R.D., Silverstein, J.N., *Antib. Med.*, 2:286, April 1956.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.



message from the President

Man dies too soon, beside his works half-planned.
His days are counted and reprieve is vain:
Who shall entreat with Death to stay his hand;
Or cloke the shameful nakedness of pain?

Send here the bold, the seekers of the way—
The passionless, the unshakeable of soul,
Who serve the inmost mysteries of man's clay,
And ask no more than leave to make them whole.

Doctors by Rudyard Kipling
(1923)

Incomparable stanzas from the gifted pen of Kipling! They epitomize his feeling toward our profession, as he knew it in England and America. This was the period when Moynihan, Osler, Murphy, Halstead and the Mayos were the scintillant stars unfolding for us the now present.

May we not with humility pause a moment in salute to the great body of unnamed physicians who, in that era, could arouse these noble sentiments in the soul of the English bard?

From them bourgeons the love and esteem with which we are held. We must hold fast, cherish this heritage. To do this, we must both earn and deserve it, no easy task in the modern maelstrom in which we live.

To be 'the bold seeker of the way', is wearisome, meticulous—requiring hours of thought and study, at times fruitless, fretful and discouraging.

To be 'passionless and unshakeable of soul'—what a towering person to be—the true megalopsuchos—for us petty men a goal for striving.

To 'ask no more than leave to make them whole'—'tis the healing apostrophe of all the ages, come to us who now hopefully guide the destinies of ailing mankind through the turbulent seas of sickness.

With Kipling, let us say:

"Lord God of Hosts, be with us yet,
Lest we forget, lest we forget."

Gant Gaither

Gant Gaither, M. D.



new Peach-flavored, peach-colored, newest liquid form of the established broad-spectrum antibiotic... TERRAMYCIN®† 125 mg. per 5 cc. teaspoonful; specially homogenized for rapid absorption; bottles of 2 fl. oz. and 1 pint, packaged ready to use.

delightful peach taste in broad-spectrum therapy

TERRABON®

BRAND OF OXYTETRACYCLINE

HOMOGENIZED MIXTURE

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y. Pfizer

†Brand of oxytetracycline

DOCTORS EVERYWHERE NOW KNOW WHY

Viceroys Are Smoother

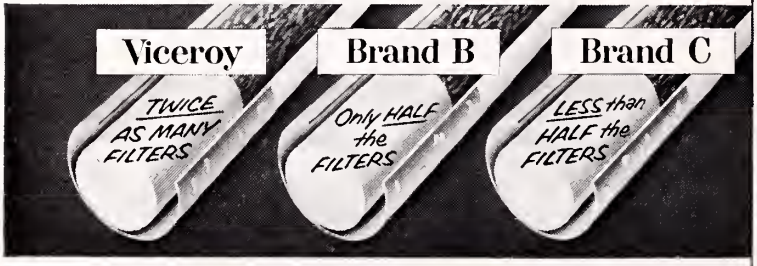


Professional men who have studied the microscopic analysis of the Viceroy filter now know why the Viceroy taste is smoother—never rough. Only Viceroy has 20,000 tiny filters in every tip—twice as many filters as the other two largest-selling filter brands. That is why Viceroys are smoother by far—never, never rough. That is why so many doctors now smoke and recommend Viceroys.

Yes, smoother taste because there are

TWICE AS MANY FILTERS IN EVERY VICEROY TIP

as the other two largest-selling filter brands!



Viceroy's exclusive filter is made from pure cellulose—soft, snow-white, natural!



plateau therapy*...

for hay fever and other allergies



CHLOR-TRIMETON
REPETABS, 8 and 12 mg.

*Because they quickly attain and maintain a prolonged, therapeutic plateau, CHLOR-TRIMETON REPETABS avoid the wave-like levels which may be produced by multiple-release granules or t.i.d. medication ...affording optimal patient comfort.

CHLOR-TRIMETON® Maleate, brand of chlorprophenpyridamine maleate.
REPETABS,® Repeat Action Tablets.

CT-J-760

IN THE BOOKS

HENRY FORD HOSPITAL, INTERNATIONAL SYMPOSIUM ON CARDIOVASCULAR SURGERY: Edited by Conrad R. Lam, M.D.; 543 pages: illustrated; published September 1955; $12.75; W. B. Saunders Company, Philadelphia.

This book is probably one of the most important single contributions yet written concerning the developing field of cardiovascular surgery. The symposium was organized by Conrad R. Lam, M. D., at the Ford Hospital. The papers presented represent the thought on cardiovascular surgery at the present time of this country and of Western Europe, as well as South America.

Diagnostic techniques were covered by papers on cardiac catheterization, the electrocardiogram is congenital vascular disease and recent developments in angiocardiography.

Symposia were given on pulmonic stenosis adjustments between the systemic and pulmonary circulation, evaluation of transposition operations, mitral stenosis and mitral insufficiency, aortic stenosis and aortic insufficiency, septal defects, cardiac arrest, hypothermia, and aneurysms and occlusive diseases of the aorta.

The various papers and symposia were discussed by many authors, all of which is recorded very thoroughly in the book. The book is an excellent review of a developing field, the very nature of which cannot be didactic at this time. The Ford Hospital is to be congratulated for organizing the symposium and underwriting the expenses of the meeting by bringing various authors from abroad who could not have been present otherwise. The book is highly recommended for everyone interested in the field of cardiovascular surgery.

John S. Harter, M. D.

DEMONSTRATIONS OF PHYSICAL SIGNS IN CLINICAL SURGERY: Editor—Hamilton Bailey, assisted by Allan Clain; Twelfth Edition; 456 Pages; $8.00; Williams and Wilkins Company.

The twelfth edition of Physical Signs in Clinical Surgery by Hamilton Bailey, M. D., is probably one of the most unique and valuable medical textbooks that has appeared in the English language. The present edition has been largely rewritten and many new illustrations have been added. The book contains 456 pages with 681 excellent illustrations which uphold the standards of other English textbooks in surgery.

The book not only illustrates many signs that are not found in the average textbook on surgery but illustrates them well, so that the reader is not lost in a maze of verbiage. Dr. Bailey is one of the outstanding surgeons in London and his vast experience has been accumulated and presented from his long teaching experience.

It would seem that the book should be a daily companion of the intern, resident and practicing surgeon, not only for basic material but also for ready reference.

One of the interesting features of this work is that in a footnote on each page one finds identification of any surgeon's name who is mentioned in the body of the text which of course is of immense value to the reader.

Since Physical Signs in Clinical Surgery has now reached the twelfth edition, it would seem that this is ample recommendation for the book and I am sure that it will be welcomed as one of the most thorough books to come off the press in the last year. It should be on every surgeons must list.

D. P. Hall, M. D.

HANDBOOK OF TOXICOLOGY: Vol. 1, Edited by William S. Spector; 408 pages; $7.00: W. B. Saunders Co., Philadelphia, 1956.

The editor and contributors have compiled an exhaustive listing of the lethal toxicity of various chemical substances for laboratory animals. Table 1 presents the lethal dose of 2120 solid and liquid chemical compounds. Table 11 denotes the lethal concentrations of 243 gases, vapors and fumes in respired air. The information is presented as tabular data on the acute toxicity of the various substances for laboratory animals.

The listings are in general by chemical nomenclature although a few trade names are used. A cross index is provided to facilitate location in the latter instances.

The specific animal used, the route of administration, and the lethal dose are listed for each item. The specific reference with the principle author is indicated for each substance.

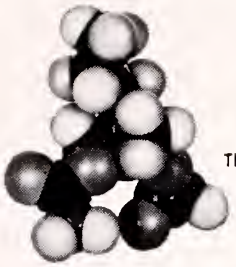
This volume is of particular value to the individual performing animal experimentation.

William Curtis Adams, M. D.

The Narcotic Educational Foundation of America has announced the availability of a motion picture "Drug Addiction—A Medical Hazard". The film, available *only* to local medical associations, nurses organizations and medical schools, is 30 minutes long and taken from actual case records. For more information about the free movie write Linus H. Bittner, M.D., Suite 5, 1645 North La Brea Avenue, Los Angeles, California.

The fifth annual Symposium for General Practitioners on Tuberculosis and other Chronic Pulmonary Disease will be held at Saranac Lake, New York, July 9-13. The course is approved for 26 hours of formal credit for members of the American Academy of General Practice. The registration fee is $40.00. For more complete information write Edward N. Packard, M.D., General Chairman, Symposium for General Practitioners, P. O. Box 262, Saranac Lake, N. Y.

Qualified physicians and other professional health personnel engaged in public health practice and preventive medicine were encouraged recently by Leonard Scheele, M. D., Surgeon General of the USPHS, to apply for commission in the Service's Commissioned Reserve. For more complete information write: Surgeon General, Public Health Service (DP), Washington 25, D. C.



THE MILTOWN MOLECULE

A tranquilizer well suited for prolonged therapy

NO ORGANIC CONTRAINDICATIONS

reported to date

- well tolerated, non-addictive, essentially non-toxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

Indications: anxiety and tension states, muscle spasm.

Miltown®

the original meprobamate—2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720

SUPPLIED: 400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.

DISCOVERED AND INTRODUCED by Wallace Laboratories, New Brunswick, N. J.

Literature and Samples Available on Request

Doctor Disabled

OFFICE EXPENSE CONTINUES

At last, here is the practical solution to this problem - - - an insurance policy to pay your expenses, with the premium eligible as a Tax Deduction.

Latest Tax ruling provides that premiums on Health and Accident insurance are not deductible unless the policy states that it is for the express purpose of meeting business overhead expenses.

Ask your Accountant or Lawyer about this question and then ask us to explain this coverage.

W. R. LONG & ASSOCIATES
1534 Bardstown Road—Louisville, Ky.

Without obligation to me I would like to have more information on your office expense policy. I am in good health and was

born .....
Month Day Year

Name .....

Address .....

Plan Now

to attend the

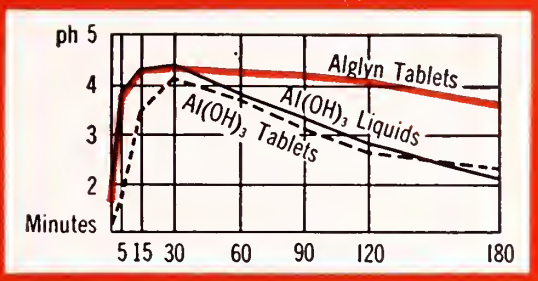
1956 KSMA ANNUAL MEETING

Columbia Auditorium
Louisville

Sept. 18-19-20

- 12 nationally known guest speakers
- three six hour refresher courses
- carefully selected scientific movies
- outstanding scientific exhibits
- 64 technical exhibits
- other top features

Announcing Revision of N.N.R. Monograph for



ALGLYN®

dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

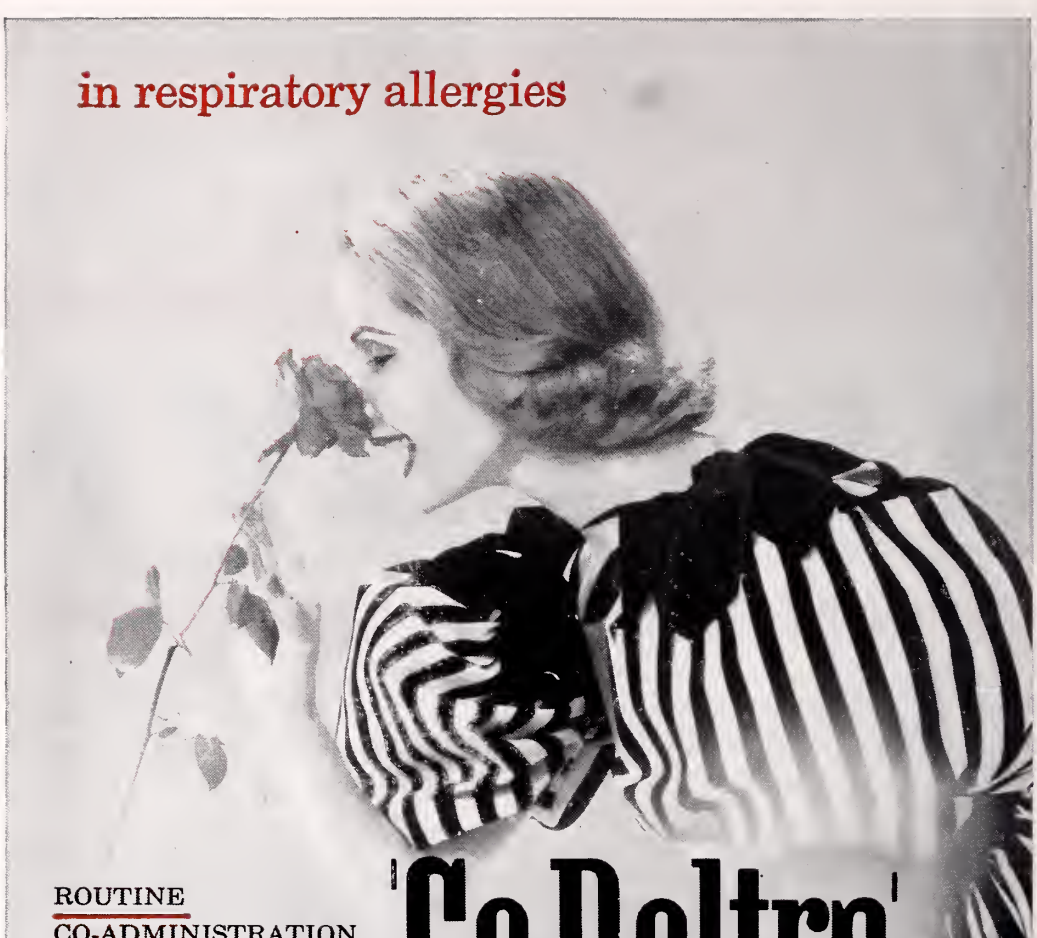
Reprint of recent in vivo studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayton PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

in respiratory allergies



ROUTINE
CO-ADMINISTRATION
MEANS

'Co-Deltra'
(Buffered Prednisone)

'Co-Hydeltra'
(Buffered Prednisolone)



Clinical evidence[1, 2, 3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

SHARP & DOHME
Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

References: 1. Boland, E. W., *J.A.M.A.* **160**:613, February 25, 1956. 2. Margolis, H. M., *et al.* *J.A.M.A.* **158**:454, June 11, 1955. 3. Bollet, A. J., *et al.* *J.A.M.A.* **158**:459, June 11, 1955.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are the trademarks of* MERCK & CO., INC.

ALL THE BENEFITS OF THE "PREDNI-STEROIDS" PLUS POSITIVE ANTACID ACTION TO MINIMIZE GASTRIC DISTRESS



little

How to win friends ...



The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION
of Sterling Drug Inc.

1450 Broadway, New York 18, N. Y.



WASHINGTON NEWS DIGEST



Washington, D. C.—Before the end of the year hundreds of thousands of dependents of military personnel, living in all parts of the country, should be receiving their medical care from private physicians and in private hospitals under the new program authorized this year by Congress. While Defense Department has not yet completed regulations to implement the act, the law itself lays down the basic principles governing the program.

The House Armed Services Committee first attempted to decide on a system or systems for furnishing private care, through Blue Cross, Blue Shield, arrangements with state medical societies, commercial insurance or "home town care," such as Veterans Administration successfully employs. But the committee gave up on the problem, and Congress finally tossed it to the Secretary of Defense by stating in the bill that he shall ". . . after consultation with the Secretary of Health, Education, and Welfare . . . contract for medical care for such persons . . . under such insurance, medical service or health plan or plans as he deems appropriate." A Defense Department task force now is attempting to decide how to work out the contracts.

Although several groups of dependents will be entitled to medical care, only wives (or husbands) and children of men on active duty will be certified for civilian care. The others will be admitted to military medical facilities on "availability of space" basis. While generally spouses and children of active duty personnel will have a choice of private or military care, there is this limitation: The Secretary of Defense may designate certain areas where private care will not be authorized, if in his opinion those areas have military facilities adequate to care for the service families.

Dependents will be required to pay the following charges: For care in military facilities, subsistence and "in-hospital" charges (set by Secretary of Defense and currently $1.75 per day); for private care, the same fees or the first $25, whichever is the larger.

The time limit on private care is 12 months, but if hospitalization still is required after this period the dependent will be protected. In this case the Defense Department will transfer the dependent to a military facility or will make direct payment to a private hospital.

Although regulations will spell out limitations and authorizations in more detail, the law makes the following provisions:

Care in military facilities to include: 1. Diagnosis, treatment of acute medical and surgical conditions, treatment of "contagious diseases," immunization and maternity and infant care. 2. Hospitalization for nervous and mental disorders, chronic diseases or elective medical and surgical treatments *but only in "special and unusual cases"* and for not more than 12 months. This would be provided at the discretion of the Secretary of Defense. Dental care not authorized except in unusual cases, while abroad or at remote stations in the U. S.

Private care will include: 1. Hospitalization in semi-private accommodations up to one year for each admission, including all necessary services and supplies furnished by hospital. 2. Medical and surgical care incident to hospitalization. 3. Complete obstetrical and maternity service, including prenatal and postnatal care. 4. Physician or surgeon's services prior to and following hospitalization for bodily injury or surgery.

Under the private care program, some services may be furnished outside the hospital, such as surgery in a doctor's office, X-rays or laboratory tests, "but not what is normally conceived to be out-patient care." If experience shows they can be afforded, additional services may be authorized, but whatever the scope of private care, it cannot exceed that furnished in military facilities. Out-patient care will be furnished by military facilities, but "uniform minimal" charges may be imposed as a restraint on excessive demands.

NOTES:

Federal appropriations for medical research are at an all-time record, explained in part by Senate approval of a 48 per cent increase over last year's funds.

Lowell T. Coggeshall, M.D., special assistant to HEW Secretary Folsom, believes some "wise changes" should be made in medical economics to facilitate payment for the "spectacular" new medical services. He expressed his views in addressing a group at the University of Pennsylvania Medical School.

Russia and eight satellites, out of active participation in World Health Organization for more than six years, now are back in; they agreed to pay five per cent of past-due assessments over a 10-year period.

The highway program contains a provision for a one-year study of traffic safety, a problem in which the American Medical Association has been actively interested for years.

BETTER

results are obtained with STERANE[1]—3 to 5 times more active than hydrocortisone or cortisone.

BREATHING

capacity is greatly enhanced. "Relief of symptoms is more complete and maintained for longer periods with relatively small doses."[2]

BALANCE

of minerals and fluids usually remains undisturbed. This proves "especially advantageous in those patients with cardiac failure requiring therapy . . ."[3]



in bronchial asthma

Sterane®

brand of prednisolone

Supplied: White, 5 mg. oral tablets, bottles of 20 and 100. Pink, 1 mg. oral tablets, bottles of 100. Both deep-scored.

1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.



a pause for reflection . . . Operation finished. You sit back and relax. Blockain* anesthesia lasted long enough with one small injection so that you were easily able to proceed from incision to closure without pause for reinjection. **Longer anesthetic duration . . .** You did that accurate reapproximation of skin edges without distortion from freshly introduced anesthetic. And more, Blockain persisted post op.—you had no complaints of uncomfortable splints, dressings or tender tissues. **Rapid onset, too . . .** You recall that the pre-incision wait was avoided. *A case to remember:* A 78-year-old patient, arteriosclerotic, poor liver function with a transcervical fracture of left femur, underwent a *one-hour-and-20-minute operation,* involving internal fixation of the fracture and the placement of a Smith-Petersen nail, with *one injection of Blockain.* Effect of anesthetic: "excellent." Onset of anesthesia: "rapid." Only 60 cc. of Blockain was used. A whiff of nitrous oxide was given at the time of actual hammering, to spare the patient emotional trauma. There were no side effects. **BLOCKAIN,** 30 cc., 0.5% (5 mg./cc.). Write GEORGE A. **Breon** & CO., 1450 Broadway, N. Y. 18 for additional information.

2-PROPOXY DERIVATIVE OF 2-DIETHYLAMINOETHYL 4-AMINOBENZOATE.

*BLOCKAIN© BRAND OF PROPOXYCAINE HYDROCHLORIDE BREON.

Adequate Hospitalization for Treatment of Alcoholics

Doctors find the modern facilities and specialized care available at White Cross Hospital meet a vital need.

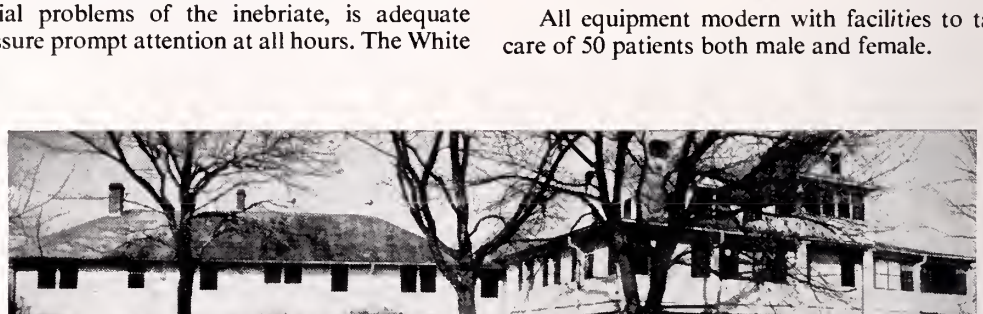
Affords Sympathetic Atmosphere, Encouraging Personal Attention, Specially Trained Staff

It is generally believed that alcoholism is self-imposed. Often in general hospitals the alcoholic patient is not considered to be "legitimately" sick, which results in the wrong psychological and emotional atmosphere that aggravates the condition. This is why more and more doctors with alcoholic cases where hospitalization is essential are utilizing the facilities at White Cross Hospital, devoted to the treatment of alcoholics exclusively. Here a sympathetic, comfortable and pleasant atmosphere—so essential to rehabilitation—is assured. The White Cross staff, trained in the special problems of the inebriate, is adequate to assure prompt attention at all hours. The White Cross Hospital is under the direction of a competent licensed physician, with five consulting physicians subject to call. Registered nurses and technicians are in charge 24 hours daily.

Safe, Effective White Cross Treatment

A private hospital offering scientific, institutional, medical, psychological, reflex, reduction and other methods for the rehabilitation of consent patients suffering from alcoholism. With the consent of the doctor and patient, the regular White Cross procedure is followed. At your request, your patient remains entirely under your supervision. You may come and go in White Cross Hospital at will, and will find the staff completely cooperative. Your recommendations will be followed to the letter.

All equipment modern with facilities to take care of 50 patients both male and female.



Salem, Va. Hospital

Approved and licensed by the Virginia State Hospital Board, Member American Hospital Association. Located atop beautiful Mt. Regis, in the quiet serene mountains of Virginia—conducive to rest, comfort and rehabilitation.

For information phone or write for booklet
Rates Reasonable

WHITE CROSS HOSPITAL

Five miles west of Roanoke on route No. 11
Salem, Virginia—Phone Salem 4761

Copyright 1955 H.N. Alford, Atlanta, Ga.

Only Meat . . . is Meat

Suppose we suddenly found ourselves in a "Brave New World," in which all the rich protein, the B vitamins (including the important B_{12}), the minerals, and all the other nutrients of a juicy steak or a succulent pork chop could be compressed into a capsule. Suppose we were to take one or two such capsules each day. What would happen?

Would we be just as healthy? Would we be as happy?

There is something about man's wish for meat that cannot be satisfied by chemical or mathematical analyses. The feeling of satisfaction, the downright enjoyment of biting into and chewing, the pleasurable effect of having eaten well . . . all these make meat more than just an impressive list of essential nutrients. Long before man knew anything about the science of nutrition he knew meat was part and parcel of his health and his joy of eating and of living.

Other foods may be fortified and enriched, *but none can ever take the place of meat.*

Only meat is meat.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago . . . Members Throughout the United States

highly successful .

- faster relief of pain, photophobia
- better control of inflammation, edema, allergy
- effective against common eye pathogens
- extremely well tolerated

now available

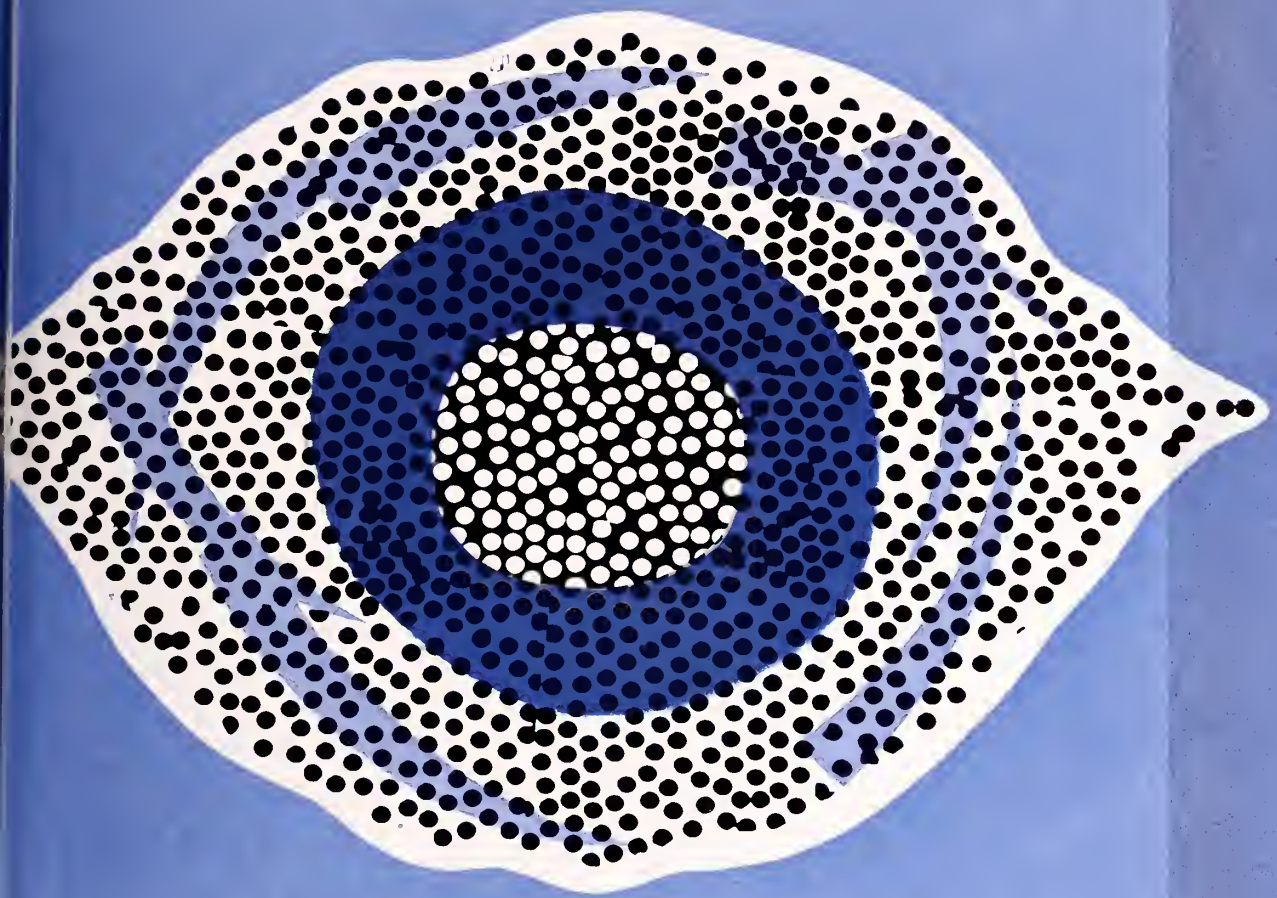
for inflammatory, allergic, infectious or traumatic eye conditions amenable to topical therapy—rapid potent, topical Meti-steroid and anti-infective action

supplied: METIMYD Ophthalmic Suspension-*Sterile*: prednisolone acetate (METICORTELONE Acetate) 5 mg. per cc. (0.5%) suspended in an isotonic buffered and preserved solution of sulfacetamide sodium 100 mg. per cc (10%), 5 cc. dropper bottle. METIMYD Ointment with Neomycin: each gram contains 5 mg. prednisolone acetate (METICORTELONE Acetate), 100 mg sulfacetamide sodium and 2.5 mg. neomycin sulfate (equivalent to 1.75 mg neomycin base); ⅛ oz. tube, boxes of 1 and 12.

METIMYD,* brand of prednisolone acetate and sulfacetamide sodium.
METICORTELONE,® brand of prednisolone.
*T.M.

MM-J-6

. in topical eye therapy



new

METIMYD*

(prednisolone acetate and sulfacetamide sodium)

Ophthalmic Suspension-Sterile

and

METIMYD

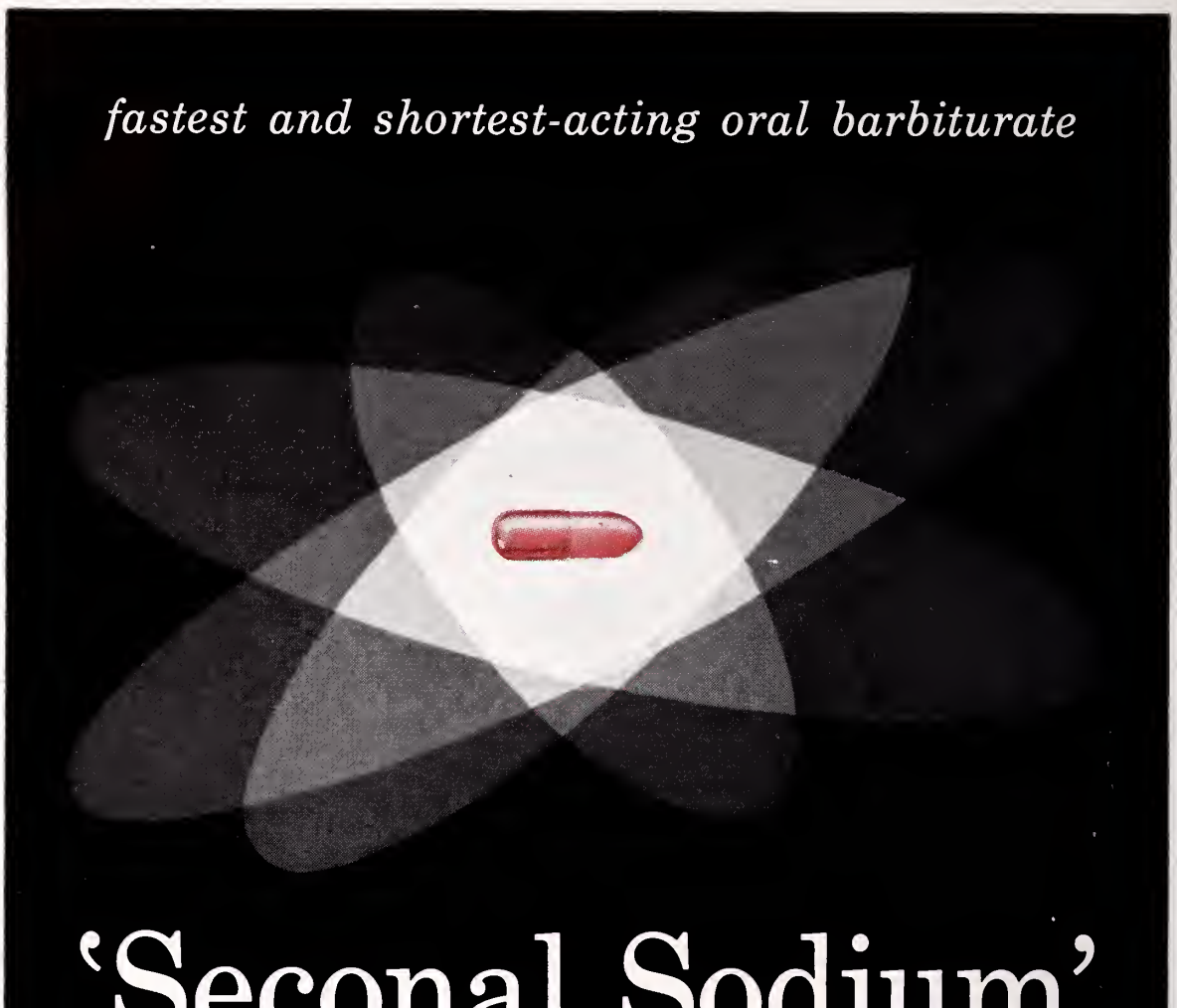
(prednisolone acetate and sulfacetamide sodium with neomycin sulfate)

Ointment with Neomycin

• antibacterial • antiallergic • anti-inflammatory

Schering

fastest and shortest-acting oral barbiturate



'Seconal Sodium'

(SECOBARBITAL SODIUM, LILLY)

822011

Lilly
QUALITY / RESEARCH / INTEGRITY

The secret of sleep in a capsule

When simple insomnia is the presenting complaint, a bedtime dose of 'Seconal Sodium' is often indicated. Its effect is prompt—within fifteen to thirty minutes; relaxation and sleep follow quickly. Your patient awakens refreshed and well rested.

Available in 1/2, 3/4, and 1 1/2-grain pulvules at pharmacies everywhere.

80TH ANNIVERSARY 1876 • 1956 / ELI LILLY AND COMPANY

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 JULY, 1956 NO. 7

CHLORPROMAZINE IN A STATE HOSPITAL*

LOGAN GRAGG, M.D.
Lexington

I WISH to discuss some of the experiences we have had at Eastern State Hospital with the use of chlorpromazine. We have to date used, in addition to chlorpromazine, reserpine, Frenquel®, Miltown®, Meratran®, and other "psychiatric drugs," but our experience is greatest with chlorpromazine, and rather than generalize on this entire group of drugs, it seems best to restrict my statements to material dealing with chlorpromazine.

At Eastern State Hospital we have been impressed, not by the reports we read, but by the results we have seen in our own hospital. Chlorpromazine is an effective drug in the treatment of the mentally ill, however, it is not a "cure-all." The mere passing out of large numbers of pills or injections is not good psychiatry, and it still requires the same therapeutic team approach to obtain the proper maximum effect upon the mentally ill patient. Our first use of chlorpromazine was organized upon this basic concept which has been strengthened by our experience.

General Statement

I do not intend to attempt any statistical report, since over 200 such reports are already in American medical literature and the world medical literature lists some 3000 such reports. Instead, I wish to make some general statements about chlorpromazine, it's usefulness, and paradoxically the problems it has created for us in the State Hospital.

We treated our first patient with chlorpromazine in June 1954, and since that time we have administered this drug to some 450 patients, of whom 285 are currently being treated. The present number is by far the largest to be under treatment at any one time, and this is possible only because through Dr. Gaines' efforts, the Governor, for this fiscal year, made emergency fund money available to the State Hospitals for the purchase of the ataractic drugs. This was necessary because our budget for this current year was fixed two years ago which was about one year before these drugs were brought into general clinical use. We, therefore, had no funds allocated for their purchase, and from June 1954 until July 1955, the patients we treated were not numerous. However, combining the small purchases which we were able to make with the supply furnished us by the manufacturer for clinical investigation, we did manage to keep under treatment an active group of patients.

Beginning in July 1955 our program of treatment has expanded rapidly, and now is near the maximum we feel can be properly supervised during treatment. Although our experience has been somewhat restricted, we have some very definite ideas about chlorpromazine based on clinical observations.

We have seen the results reported by others; such as astounding tranquilizing effects upon the acutely violent patient newly admitted to the hospital, with definite shortening of hospital stay. We have also seen chronically disturbed psychiatric patients, with a variety of diagnoses, becoming much better hospital patients, and even becoming eligible for home visits. In patients in whom agitation, anxiety and irritability are not prominent symptoms, results are not so consistent.

Observed Benefits

Although we have done no minutely controlled research, our experience with the actively disturbed State Hospital patient has proved to us, beyond any doubt, that this drug produces an unique and extremely beneficial

*Presented at the 1955 KSMA Annual Meeting in Louisville, Sept. 28-30.

effect upon the great majority of such patients. The answers to the exact how and where of chlorpromazine's action will be provided by research investigation.

We find definite indications for this drug in certain symptomatic categories of patients, without much regard to diagnoses.

First, as I have mentioned, the hyperactive, agitated patient, either newly admitted, or long term, should receive the drug, and benefit is almost certain, at least to the point of diminishing activity and agitation. The patient is then a better hospital patient, if continued hospitalization is necessary.

We find that many of our geriatric patients respond very well to relatively small doses of this drug, and so we feel that many old people may be saved from hospitalization if proper use of chlorpromazine can be made by their own doctors at home.

The other large category of patients to whom the drug is being given, is the "long term psychotic." These patients have hallucinations and delusions, and are described as regressed or deteriorated. The results, percentage-wise, are not so good with these patients but when they do respond, the result is dramatic.

We have made no effort to replace electric shock, or any other form of therapy, by the use of chlorpromazine. We have made it an additional item in our therapeutic program. There has been a very definite reduction in the need for maintenance electric shock treatment in the chronic patients. There has also been a very marked reduction in seclusion hours during the past six months. Our hospital has also experienced a small drop in census during 1955, despite an increase in admissions, indicating that our present program including chlorpromazine, along with every other therapeutic medium we can employ, is increasing our therapeutic effectiveness.

We feel that some of the more spectacular results reported from the use of this drug must be examined rather closely. We cannot duplicate all of the remarkable feats reported by other hospitals about the country. A New York hospital reported that mattress destruction was reduced from about 24 per day to none. Other hospitals reported a mass exodus of patients suddenly able to resume their place in society. At our hospital an intensive electric shock treatment program among the disturbed patients during the past three years, had long ago eliminated such things as mattress destruction. We feel that when introduction of chlorpromazine enables a great number of patients to be released within a very short time, this indicates that prior to the use of chlorpromazine, no active treatment program had been in effect with those patients. We are releasing patients as a direct result of chlorpromazine treatment, but we find it a much more gradual procedure.

New Problems Created

The following comments, I feel, cover an aspect of the use of this drug that has been neglected, and which should be pointed out for clear understanding of just what effect this drug really is having on State Hospital psychiatry.

Progress always produces new situations and new problems in whatever field it may occur. This is true for us as a result of the beneficial effects of chlorpromazine. Because of its demonstrated ability to affect favorably the psychotic patient, the hospital administration has had to meet the problem of the improved violent ward patient, both individually and as a group. We have to admit that in our disturbed wards, one male and one female, with about 175 patients, there was little in the way of a real intensive treatment program. Electric shock treatment was used intensively, and while this greatly reduced the destruction and need for seclusion, the patients were too irritable and unpredictable for us, with minimal personnel, to set up activity programs, except on a very minor scale. With chlorpromazine the most disturbed patients on these wards show improvement and the entire ward picture is altered. The improved ward behavior makes it necessary for us to find ways to extend occupational therapy and recreational programs to these wards. For departments already too heavily loaded, this has been difficult to do, but it has been done. There is also necessary a re-orientation of ward personnel's outlook in the change of the ward situation, from a place of turmoil, to one where purposeful activity can be followed by patients.

In addition to the increased need for ancillary services on our acutely disturbed wards, the same type of problem arises for the hospital in general. There are patients on all wards who have not been on an activity program, and who, with improvement as a result of chlorproma-

zine, must not be denied these additional therapeutic efforts. Chlorpromazine thus increases our need for all of the ancillary services.

This, I think, is the real heart of our problem here. We have seen some dramatic results with chronic, severely ill patients in our disturbed groups. Improvement to a remarkable degree may occur purely with the administration of a few pills a day. There comes a time, in most cases, however, when we have a better hospital patient, and that is all. That is when our ancillary services become essential. It takes all the "personal touch" we can apply to an individual of this type, if we are to bring him to the state in which home going really will be indicated.

I am afraid that some hospitals are sending "quietly psychotic" patients home, establishing enviable statistical records for themselves, but actually not doing the best psychiatry because they are not fully utilizing all the other therapeutic tools available. To do this adequately requires more trained personnel, and in settings like ours, more time and effort from our personnel, who are already carrying too heavy a load.

With the use of chlorpromazine a certain number of long term patients subject to constant, or frequent episodes of disturbed behavior are so benefitted that hospital supervision is no longer necessary. Such a patient may have been hospitalized five, 10, 15 or more years. He should not continue to be hospitalized if it is no longer necessary. However, it obviously will not be a simple matter to return such an individual to his home. The patient is thoroughly institutionalized, and the family situation is vastly altered, so that the patient's place in the family circle no longer exists. We increasingly will face this problem, as we have more patients under treatment, and it will require a great deal of pre-release work with both the patient and the family. The matter of vocational rehabilitation of such long term hospital patients is not a new problem, but also will increase as a result of chlorpromazine treatment in our State Hospitals, and to date there is little or no provision for this type of aid to our patients.

Disposition and Re-admissions

Another problem we are having to face at present is disposition of patients who should remain on maintenance chlorpromazine and who may go home to one of our remote mountain areas, or into a family not likely to expend the $10.00 or $20.00 needed monthly for medicine. Before such a patient goes home, we must be sure that the medication is available in his home town, and that his family realize the importance of continuing treatment. We must be sure that medical supervision is available to him, since from the areas served by our hospital it is difficult, if not impossible, for many of our patients to return to us for supervision, even if we had provision for such out-patient care. Thus the release of such patients will require much time and detailed work on the part of our staff.

Before the use of chlorpromazine, the re-admission rate was on the increase in our mental institutions. It would seem that with the increased treatment program in our State Hospitals, more patients recover from psychotic episodes, and are released, but there are no facilities for non-hospital psychiatric attention in their home situations, and relapses occur. We anticipate that until facilities for out-patient care are available, this trend will be increased, rather than decreased. Many patients who would not otherwise leave the hospital, may be able to do so, but will not receive the necessary psychiatric attention, and will suffer relapses necessitating additional periods of hospitalization. Despite the increase in re-admissions, we feel that the net result should be fewer hospital days for these patients.

Summary and Conclusions

1. We feel that chlorpromazine is extremely useful in the treatment program for any patient in whom agitation, irritability and anxiety are prominent.
2. We do not feel that it is the final answer in the treatment of any specific disorder.
3. We find that it opens hospital doors more quickly for some, and for others it opens the door when all else has failed.
4. We present no theory as to its mode or site of action.
5. As a direct result of chlorpromazine's beneficial effect, we are finding our ancillary services hard-pressed to include the many patients formerly too disturbed for therapeutic activity.
6. The release of long-term, chronic patients presents new problems in rehabilitation and home planning which we must meet.

SURGICAL TREATMENT OF LYMPHEDEMA*

William T. Swartz, M.D.
Lexington

I FIRST became interested in elephantiasis when during my internship I saw two young patients with Milroy's disease undergo multiple Kondoleon procedures without success. Since that time a more rational surgical approach has evolved which should offer help to these patients.

The term elephantiasis arose during the Roman Army's campaign in Libia where natives were captured who had tremendous swellings of either leg or scrotum in which not only the size of the part but the contour of the skin reminded the observers of the hide of elephants.[1] These early cases were no doubt primary or specific lymphedema due to lymphatic blockage by filarial worms. This type is of recent importance for in 1943, for example 5,646 Marines and Sailors had to be evacuated because they were infected with this lesion.[2]

The etiology of lymphedema is varied. Primary, or specific lymphedema follows invasion of the lymphatic system of the extremity by the filarial worm (Wuchereia bancrofti) in the majority of cases, and by the Mycobacterium tuberculosis, or Treponema pallidum in rare instances. Infectious lymphedema frequently follows secondary invasion of the lymphatics by streptococci. Malignant tumors cause lymphedema by obstructing the lymphatic channels. In occlusion of a major vein in an extremity, the overload on the lymphatic system is evidenced by lymphedema which improves following recanalization of the thrombosed veins. However, in severe postoperative thrombophlebitis, or in the so-called milk leg following pregnancy (phlegmasia alba dolens) secondary lymphatic inflammation may cause permanent lymphatic obstruction. Idiopathic lymphedema of the lower extremity, which becomes pronounced at puberty—first described by Unna (1890) and later popularized by Milroy (1892) is known as Milroy's disease. Some authors attribute this condition to an endocrine disturbance since it becomes manifest at puberty; others feel that it represents a congenital lack of adequate lymph vessel drainage.[3]

Surgery, x-ray, radium, third degree burns, keloid formation, trauma or circumferential avulsion of skin and subcutaneous tissue may result in lymphatic blockage secondary to interruption of lymphatic pathways. This type may not manifest itself until many years following the original injury, after recurrent bouts of lymphangitis have blocked more and more lymphatics and the process has become irreversible.

Anatomy

The lymphatic system of the lower extremity is an endothelial lined progression of lymphatic capillaries, collecting vessels, lymph glands and lymph channels containing lymph and serving to return waste products from the periphery into the general venous circulation by way of the thoracic duct. Very abundant superficial and deep lymphatic capillary plexuses are located in the skin; however, lymph vessels, glands and channels are encountered in the subcutaneous layers. Lymph drainage proceeds from the capillaries, through the vessels, channels and glands.

In the lower extremity, as in other parts of the body, there are superficial and deep groups of both glands and vessels. The superficial inguinal lymph glands are arranged in two groups: an upper group, spread out beneath the junction of the membranous layer of the superficial fascia and the deep fascia of the thigh, and a lower group placed along both sides of the upper portion of the saphenous vein. Both of these groups lie just superficial to the deep fascia. The superficial lymph channels contain few valves and, as supported by clinical evidence, apparently do not anastomose with deep channels that drain the muscles of the leg.[4] The superficial group of lymph vessels drain the skin and subcutaneous tissue of the thigh, anterior leg and dorsum of the foot. They follow the superficial veins lying on or near the deep fascia and drain into the superficial inguinal nodes. A relatively small area from the sole of the foot and leg drains into glands within the popliteal fossa.

Rich lymphatic capillaries are present within the muscles, tendons, joints and bones. Their

*Presented before a meeting of the Fayette County Medical Society

channels follow the deep veins beneath the deep fascia and drain predominantly into glands located about the femoral and iliac vessels. Semilunar type valves are much more abundant in the deep channels than in the superficial pathways. Unlike the venous system, there is very little overlay in lymphatic drainage areas, for once a channel is blocked, there is very little possibility for the substitution of collateral channels.[3] The functions of the peripheral lymphatics are mainly to aid in normal drainage of the extremity and to form a defensive barrier against the spread of infection or malignant tumors.

Pathology

Inflammation of the lymphatic system, termed lymphangitis or lymphadenitis, similar to that in a vein with thrombophlebitis, may cause changes within the wall of the lymphatic vessel. These inflammatory changes are followed by fibrous thickening and scar tissue proliferation with obliteration of the lymphatic channels. When this occurs there is stasis of lymph within the rich lymphatics of the skin and massive swelling ensues, which is at first pitting and later brawny. Chronic lymphedema of an extremity is characterized by this diffuse swelling of the part. As the process progresses there is an increase in the interstitial fluid, and a diffuse fibrosis involving all layers of tissue superficial to the deep fascia of the extremity.

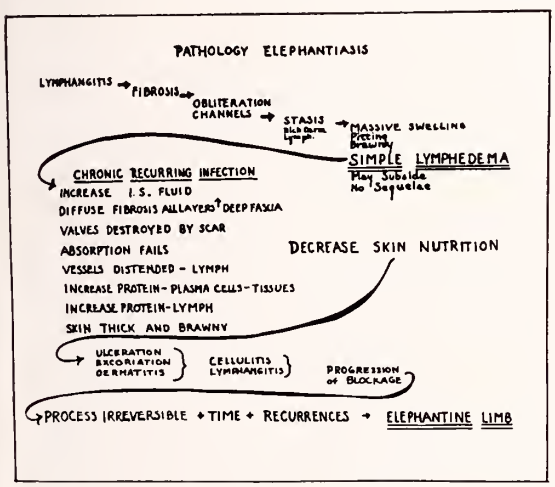


Fig. 1 Pathogenesis of the elephantine limb.

In the initial phase of the process there is pitting edema which disappears on elevation and is usually confined to the distal part of the extremity. The lymph vessels in the subcutaneous tissue and capillary plexus in the dermis are involved initially. This process may subside without sequelae. If it progresses, the edema becomes brawny and is not relieved by elevation. The lymphatic valves become incompetent due to scarring; absorption fails and the vessels become distended with lymph. The surrounding tissues contain tissue proteins and large numbers of plasma cells. The protein and fibrinogen content of the lymph increases, stimulating fibrosis. As this condition persists, the skin becomes thickened and brawny with eversion of the pores. Interference with nutrition of the skin favors ulceration, excoriation and dermatitis. The leg then represents a fertile site for cellulitis and lymphangitis which in themselves cause a progression of the lymphatic blockage and fibrosis. At this stage the changes are irreversible.[5]

That chronic recurring infection is a necessary factor for the development of elephantine limb was stressed by Halsted[6] in 1921 and later by Roberts. "Simple lymph edemas are the results of stasis—add the factor of infection and we have an entirely different picture, that of elephantiasis. Chronic infection usually caused by streptococcus after a time rapidly leads to progressive hypertrophy or hypodermal and dermal connective tissues. Simple mechanical blockage of the lymphatics causes regional lymphedema, but the characteristic fibromatosis and histologic changes peculiar to the elephantoid state cannot be produced without pyogenic infection."[6]

Treatment (Historical Review)

The obvious treatment is correction of the underlying cause. Contact with those infected with filaria must be broken in that type. Elevation, rest, supportive bandages, meticulous cleanliness and control of fungus and pyogenic skin infections, is indicated in all cases. In this conservative treatment the part must be elevated enough to reduce the swelling and supported enough to maintain this reduction with dependency. The part should be raised above the level of the heart at night and each time swelling occurs during the day. At first this may require 10 or 15 periods of elevation a day. The lymph fluid must not be permitted to escape into the subcutaneous tissues and stimulate fibrosis. That elevation is of importance has been proven by reduction of swelling fol-

lowing iliac vein ligations from 35 to four per cent with attention to this one detail alone.[7]

Of equal importance is support which maintains decompression once the elevation has eliminated the fluid. If swelling occurs the part must be elevated until the swelling subsides. Good elevation for 30-40 minutes usually reduces this swelling. An Ace bandage is superior to elastic stockings because of its uniform pressure and the fact that it can be adjusted to take up any slack. In most patients with so called milk leg, a program such as this if instituted early and followed through will be effective. Vasodilators, massage, physical therapy have helped many of this mild group.

Repeated courses of specific antibiotic therapy may be indicated. Often when attacks of secondary infection can be prevented for some time they do not recur. Patients with mild to moderate chronic lymphedema and especially those seen early after a thrombotic syndrome may respond well to sympathectomy. In these latter cases venous thrombosis overloads the lymphatic system—sympathectomy releases spastic element associated with the process improving venous circulation and therapy takes the load off the lympatics.

This presentation, however, is concerned with the problem of massive lymphedema, the elephantine limb, with which the patient is physically and psychologically disabled. The size of the limb makes him a monstrosity, the recurrent lymphangitis and ulcerations make him an invalid. Surgical correction of the residual lymphatic mass is indicated for physical comfort and rehabilitation.

Early operative procedures date back to the early nineteenth century when Lisfranc advocated obliteration of the lymphostasis by scarification. Others advocated ligation of the femoral or iliac vessels in attempts to reduce lymphostasis. These measures usually resulted in no improvement, massive infections, or led to amputation. In 1908 Handley attempted canalization of the obstructed areas by placing long silk sutures at the subcutaneous level. In 1945, a similar maneuver using nylon was employed by Ransohoff. Fascial strips and rubber tubing have been used in a similar manner but without conclusive results. The response in these cases is thought to be due to lymph leakage rather than to the lymphatic channels which have been created.[5]

In 1938 Gillies and Fraser used a bridge of skin and subcutaneous tissue with its normal lymphatics to by-pass an inguinal obstruction and drain lymph into axillary nodes. They reported fair results. Mowlen attempted to drain the subcutaneous lymphatics of the thigh by bringing the omentum out beneath the inguinal ligament. The results were encouraging, however, the danger of herniation was thought to be considerable.[5]

Most present-day surgical procedures are modifications of the Kondoleon procedure. Originally published in 1912, this operation was based upon the establishment of communications between the subcutaneous tissue and the deep muscle by excision of strips of deep fascia. Because of disappointing results, the operation was later modified by Sistrunk to include more extensive removal of skin and subcutaneous tissue. The inherent failure in these procedures seems to be the inability to maintain the postoperative decrease in size of the extremity and the recurrence of lymphangitis and cellulitis. This may be because large portions of diseased tissue remain in the extremity.[5]

Homans in 1936 and more recently Pratt advocated complete excision of the subcutaneous tissue and deep fascia of the calf, with 75 to 85 per cent excision of these structures in the thigh, if involved, the remaining full thickness skin then being approximated directly to the muscle. They were of the opinion that there was some communciation established between the grafted full thickness skin and the deep muscle lymphatics. Other authors felt that the benefit in these was probably due to the plastic excision of the lymphatics rather than the creation of anastamotic lymphatic channels. In 1947 Macey emphasized that recurrent cellulitis could be controlled only by complete excision of the disease bearing area. In 1950 Molem, advocated total excision of all the subcutaneous tissue of the leg with preservation of the full thickness skin only over the anterior tibia and tendon achillis. Secondary split thickness grafting of the extremity was then carried out. In the same year Blocker reported six cases of elephantiasis of the lower extremity treated by radical block excision of all skin and subcutaneous tissue down to the muscle and periosteum of the tibia covered by large split thickness dermatome grafts.[5] Pratt

recently reported 25 cases treated by this technique. His results were very satisfactory. There have been no recurrences of lymphedema, the first two cases in his series having been done three years ago. These results far exceed previous techniques in which one third were unsatisfactory.[7] The following case illustrates this technique.

Case Report

A 55 year old white male suffered a gunshot wound in the upper third of the left thigh in 1918. The original wound was allowed to granulate in and healed secondarily within six weeks. For the next six years the patient's life was uneventful. However, eight years following the original injury he began to notice an increase in the size of the left thigh and gradually developed a non-tender swelling of the left lower leg, associated with a thickening and crusting of the skin. In 1937 a Kondoleon procedure was performed on the lateral aspect of the left leg. Three months after surgery there was complete reaccumulation of the swelling. A second Kondoleon operation was performed along the medial aspect of the left thigh and leg in 1939. In three months the swelling returned. The leg gradually increased in size until hospital admission.

For several years prior to admission the patient had worked as a gardener and on several occasions lacerated his leg with a sickle. Following these lacerations he described a tremendous amount of fluid pouring from his leg, causing subsidence of the swelling and relief of symptoms, which although temporary, was quite gratifying. Although the leg was a cosmetic problem, he had very good function and continued his occupation as a gardener. Three weeks prior to admission he suffered an abrasion on the lower aspect of the left leg which proceeded to drain fluid. This subsequently became tender, the entire leg became red and indurated and the patient became febrile. It was because of these acute symptoms that he was admitted to the hospital.

The entire leg from the knee to below the malleoli was involved in diffuse, brawny swelling which did not pit. Thick, crusted, pig-like skin covered the entire area. The left mid-calf measured 60 cms. in diameter; the right measured 36 cms.

The patient was placed on bed-rest with elevation of the leg and antibiotics. Within 14 days there was moderate subsidence of the edema. (Fig. 2)



Fig. 2 Appearance of extremity at time of surgery.

Operation

Under a tourniquet, a complete excision of all tissue superficial to the muscles of the calf and periosteum of the tibia was carried out. The entire thickened and indurated mass of tissue which formed the lower leg was excised in a single piece down to the muscle bellies. Split thickness skin was taken from the abdomen and right thigh. A massive pressure dressing was applied. During the procedure, 500 ccs. of blood were given.

Microscopic sections showed diffuse subcutaneous fibrosis and lymphatic infiltration with an abundance of dilated lymph and blood vessels scattered throughout the subcutaneous layer.

Postoperative Course

He was given antibiotics for a period of 10 days. On the twenty-fifth postoperative day, patient began dangling his leg from the side of the bed for a period of five minutes each hour. This time gradually increased until there was no discoloration or swelling encountered on dependency. By the thirty-fourth postoperative day he was up in a wheelchair and walking to the bathroom. At this time there was slight edema of the dorsum of the foot which was readily controlled by elastic bandages. On his fortieth postoperative day, he was discharged from the hospital. When seen 17 months following surgery, there was no swelling of the leg. The grafted area showed no ulceration or evidence of breakdown. The extremity was non-tender and had good function. The tendo

achillis glided beneath the graft without limitation. Calf measurements of the left correspond to those on the right. (Fig. 3)



Fig. 3 Nontender, good functioning cosmetic extremity—17 months after surgery.

Summary and Conclusions

1. The anatomy, etiology, pathology and therapy of lymphedema have been briefly reviewed.
2. A case is presented of chronic lymphedema of the lower extremity secondary to a gun shot wound of the thigh. The elephantine process began to develop six years after injury and led to two unsuccessful Kondoleon procedures 19 and 21 years later. Because of the elephantine proportion and recurrent bouts of cellulitis and lymphangitis the patient became a candidate for radical excision of all involved tissue. Seventeen months follow up revealed an extremity of much greater functional and cosmetic value with no evidence of recurrence of cellulitis or edema.
3. Chronic elephantine extremities can be reduced to near normal size by complete excision of the involved skin and subcutaneous tissue. This can be accomplished expediently in a one stage procedure followed by extensive split thickness skin grafting.

Bibliography

1. Allen, E. V.; Barker, N. W., and Hines, E. A., Jr.: Peripheral Vascular Disease, Philadelphia, W. B. Saunders Co., 1946.
2. Pratt, Gerald H.: Surgical Correction of Lymphedema. J. A. M. A., 147, No. 12:1121, 1951.
3. Pratt, Gerald H.: Surgical Management of Vascular Disease. Philadelphia, Lea and Febiger, 1949.
4. Mowlem, Rainsford: The Treatment of Lymphoedema. Brit. J. Plastic Surg., 1:48-55, 1948.
5. Longacre, J. J., and Swartz, W. T.: Surgical Treatment of Elephantiasis of the Leg: Report of a Case. Ohio State Med. J., 48:324, 1952.
6. Halsted, W. S.: Elephantiasis Chirurgica—Its Causes and Preventions. Bull. Johns Hopkins, Vol. XXXII, No. 369, p. 309.
7. Pratt, Gerald H.: Surgical Correction of Lymphedema. J. A. M. A., 151, No. 11:888, 1953.

SOME EFFECTS OF GENERAL ANESTHETIC AGENTS ON THE HEART*

David A. Davis, M.D., Kenneth Boniface, M.D., Charles Whitcher, M.D.
Chapel Hill, North Carolina

MANY patients who face anesthesia and an operation express grave concern as to whether or not their hearts are able to withstand this combination of insults. Usually reassurance is given and, as a rule, patients do tolerate anesthesia and operation with surprisingly few manifestations of cardiac dysfunction. That this is true is based much more on the inherent ability of the cardiovascular system to tolerate an insult than on any factual knowledge regarding the performance of the heart as it is subjected to the stresses and strains of anesthesia, operation, and recovery. It is unfortunate that many of the impressions regarding the effects of anesthetics on the heart are based more on statistics of survival than on actual measurements of cardiac function while the heart is under the influence of these drugs.

Our Present Ignorance

There are many reasons for our ignorance of the effects of anesthetic agents on the heart.

*Presented at the 1955 KSMA Annual Meeting in Louisville Sept. 28-30.

Probably the principal difficulty arises from the extremely large number of variable factors which must be evaluated, the limitations in methods for their evaluation, and the speed at which some cardiovascular derangements occur. For more than 50 years the only method of monitoring cardiac function during anesthesia was palpation of the peripheral pulse. To this was added measurement of blood pressure by the anesthetist and with few exceptions pulse rate and blood pressure estimations constitute the principal means of evaluating circulatory efficiency today. Within recent years electrocardiography has found a limited usefulness in the operating room and certainly this valuable aid will find a more extensive application in the future. It is to be hoped that as better methods of investigation are developed and more physicians become concerned with circulatory problems during surgery, more factual information will be accumulated and permit the anesthetist to know, rather than guess, the status of the patient.

The average patient may undergo anesthesia for an appendectomy exhibiting few changes in the so-called "vital signs." This is not necessarily a tribute to the conduct of anesthesia, but rather to the tremendous ability of the cardiovascular apparatus to withstand stresses imposed upon it. The blood pressure is not in itself an index of cardiac function but simply represents the resultant of several factors which are remarkedly well integrated. The principal factors which maintain arterial pressure are the cardiac output, the blood volume, the peripheral resistance, and the elasticity of the vessels. The normal heart muscle can carry out work nine times that required in the basal state. The peripheral vessels can dilate and constrict within very wide ranges in order to keep the reservoir pressure within a narrow range and compensate for blood loss or other alterations in hemodynamics. The fact that a blood pressure remains "normal" does not mean that the circulation has not been adversely affected. The myocardium may be depressed but arterial pressure maintained by vasoconstriction or other reserve forces. The fact that a pulse rate remains slow is generally considered to be a favorable sign. On the other hand, it is quite possible that this slow pulse is simply due to the fact that the heart is no longer able to compensate by acceleration and is nearing the breaking point. That the pulse beats with a regular rhythm is not necessarily an indication that all is well, for dangerous conduction defects may be associated with a regular rhythm. The fact that in the presence of hemorrhage, blood pressure and pulse rates remain stable may simply mean that the circulation has compensated to its utmost by vasoconstriction and give no hint that the patient is bordering on irreversible shock. The electrical activity of the heart may be maintained well in the presence of a marked change in blood pressure, and give little warning of impending coronary insufficiency. Quite often, then, it is probable that a state of apparent normalcy exists as measured by ordinary methods when actually the cardiovascular status is distinctly abnormal. As long as compensatory mechanisms hold out, the patient will survive but, when compensation breaks, a catastrophe may occur very suddenly.

Any discussion of the effects of anesthetic drugs on the cardiovascular system is forced to include two other factors which are constant threats and which are often extremely difficult to recognize. These are hypoxia and hypercapnia. More and more evidence points to damage produced by these culprits whose attack may be very insidious and require several hours before disaster is produced. To these might be added other factors which are often unrecognized such as bleeding, alterations in body temperature, reflexes of vagal or sympathetic origin, blood volume deficiencies, and the impatience of surgeons and anesthetists.

Illustrative Cases

Perhaps some of the adverse cardiovascular effects produced by anesthetics and anesthetists might be described best by the use of illustrative cases. During the past few years we have had an opportuniy to study a rather large collection of cases which terminated in death or a very narrow escape from disaster. The pattern in many of these cases is so similar that it is reasonable to assume that the basic mechanisms were quite similar also and from these cases certain conclusions can be drawn.

Case I. An elderly man, rather debilitated, anemic, and arteriosclerotic was suffering from

a tumor presenting itself in the midline of the back and thought to arise from one of the thoracic vertebrae. Because of the rather pitiful condition of the patient and the desire to obtain a substantial piece of tissue, general anesthesia was decided upon, using endotracheal technic because of the prone position required for the procedure. To facilitate intubation, a barbiturate combined with a muscle relaxant was given intravenously rapidly and intubation carried out. It was then noted that carotid pulsations were no longer visible nor could a radial pulse be detected. Accordingly cardiac massage was thought in order. As the interspace was felt for, feeble cardiac pulsations were noted and increased rapidly in intensity. Within a few minutes blood pressure was normal and the operation carried out without further incident. The patient apparently recovered satisfactorily but died suddenly a few days later.

This case illustrates the primary circulatory depression which may be produced by an intravenous barbiturate. If one follows closely the blood pressure during induction of barbiturate anesthesia there will be noted consistently a fall in blood pressure which tends to reverse itself and approach normal within a few minutes. Experimentally it has been shown clearly that barbiturate anesthesia markedly depresses the contractility of the heart and the cardiac output. The degree of depression varies somewhat with the speed of injection. Pulse rate changes are variable. In the presence of an adequate blood volume, blood pressure is maintained by peripheral vasoconstriction in the face of myocardial depression and diminished venous return. That the above patient survived the experience is a tribute to no-one. All of the factors important in the development of this circulatory collapse should have been recognized before induction. If barbiturate induction had still been chosen, the speed of injection should have been very, very slow. "Shotgun" methods of induction have become quite popular in recent years, but in an occasional case a degree of circulatory depression sufficient to cause death may occur.

Ethyl ether has obtained the reputation of being the safest agent to use in the presence of cardiac disease. This opinion is backed by a large number of individuals and by thousands of cases of survival. It is not intended to dispute this, but for some reason the feeling often is obtained that ether is actually beneficial to the cardiovascular system. Nothing could be farther from the truth. Again experimental evidence points to the myocardial depressant effects of ether, with most marked depression in deeper planes of anesthesia. Without the compensatory mechanism of sympathoadrenal discharge, even light ether anesthesia may result in a profound degree of circulatory depression. Clinically this is borne out by the extreme hypotension which follows sympathectomy or adrenalectomy under ether anesthesia.

Case II. An obese female with a long-standing obstruction of the colon was anesthetized with cyclopropane and maintained on ether-oxygen. When the plane of anesthesia was deepened to facilitate the battle with the distended intestines, no blood pressure could be obtained, but a satisfactory pressure would return and be maintained when light anesthesia was used. To permit closure of the abdomen, a small dose of curare was given. The abdominal wall was closed, but it was not until several hours later that paralysis produced by curare had worn off to the point where it was thought safe to return the patient to the ward, where she died a few hours later in a progressive hypotensive state.

This case illustrates several points of importance. In the first place it shows the depressant effect of ether on the circulation in the presence of toxemia and hypovolemia and with these, an inability to compensate for myocardial depression. Secondly, it illustrates the hazard of combining ether anesthesia and curare, a point which has been emphasized so many times. In the third place, it demonstrates the insidious nature of hypoxia and hypercapnia which probably combined in the operative and postoperative period to help produce hypotension and death. In the light of recent work, it can be assumed that hypercapnia contributed greatly to the prolonged muscular weakness which followed the injection of a muscle relaxant.

Case III. A young man with severe bronchiectasis was anesthetized with cyclopropane for a lobectomy. Sputum was particularly copious and frequent tracheal suctioning was necessary. During the hilar dissection the stim-

ulus merely of touching one particular area was followed by a marked hypotension with bradycardia, the typical vago-vagal reflex so often described. The "irritable focus" was infiltrated with procaine and the operation completed uneventfully.

Case IV. A child was anesthetized with cyclopropane and a right middle lobectomy carried out. The anesthesia and operation were quite smooth during the lobectomy. The patient was deliberately deeply anesthetized to furnish optimal operating conditions. Prior to closure of the chest the lungs were inflated twice with oxygen, and tracheal suction carried out. At this point, the heart became irregular and during the next four hours, in spite of (or perhaps because of) various drugs, failed to resume a normal rhythm. Frequent runs of ventricular tachycardia were observed electrocardiographically during this time.

Case III and IV represent ground for attack by the opponents of cyclopropane. Likewise, in these patients, the association of cardiac irregularities with tracheal stimulation offers good evidence of vagal reflex action which has so frequently been blamed for circulatory disturbances. But other factors also play a part. Both of these patients were undoubtedly hypercapneic, and in Case III hypoxia cannot be ruled out. Evidence has been presented to show that in humans anesthetized with cyclopropane, cardiac arrythmias do not occur if carbon dioxide elimination has been carried out properly.

In the dog, the effects of vagal stimulation and the incidence of epinephrine-cyclopropane arrythmias are influenced greatly by the state of oxygenation and carbon dioxide elimination. In the human, direct electrical stimulation of one vagus has been carried out, and it has been shown that the cardiac effects are negligible unless hypoxia or hypercapnia is present.

In Case IV, there is little doubt that considerable carbon dioxide retention occurred and that this hypercapnia was rapidly corrected when the lung was vigorously and repeatedly inflated. If dogs are allowed to breathe high concentrations of carbon dioxide for a few hours, little alteration in circulation occurs. If, then, this carbon dioxide is suddenly removed, a rapid deterioration of circulation occurs and ventricular arrythmias appear which are often fatal. This sequence of events is probable in Case IV. It has been shown that during both the period of hypercapnia and its correction, marked shifts in electrolytes occur which might account for these deleterious effects on circulation. It is doubtful that any single factor contributes exclusively to this circulatory derangement, but certainly both the development of hypercapnia and its subsequent correction can play an important role in circulation during anesthesia.

The older literature has often emphasized the part which deep anesthesia plays in protecting the heart from noxious reflex stimuli. While certain reflexes can undoubtedly depress or stimulate the circulatory apparatus, more and more evidence points to the fact that these reflexes are of minor significance provided the status of ventilation is adequate. The experience of Artusio with ether analgesia for cardiac surgery would seem to bear this out.

Summary

In essence, then, it is probably fair to state that all general anesthetic agents with the possible exception of nitrous oxide and ethylene, produce alterations in circulatory dynamics which may or may not be recognized. Whether or not the patient survives anesthesia and surgery must depend to a large extent on the ability of the patient to compensate for the depressant effects of anesthesia; and certainly the avoidance of the additional effects of hypoxia, respiratory obstruction, hypercapnia, blood loss, and excessive surgical trauma are of tremendous importance in the maintenance of the integrity of the physiological reserves.

A UROLOGIC PERSPECTIVE OF ABDOMINAL TUMORS**

FRANK M. WOODS, M.D.*
Miami, Florida

THE motivating influence that prompted the writing of this paper was the discrepancy between preoperative and postoperative diagnoses in the surgical correction of abdominal tumors, in a series of cases. Errors in judgment are human but we cannot be forgiven for not using all means at our disposal to diagnose accurately a condition before subjecting the patient to major surgery. The purpose of this paper is to call to your attention the value of three dimensional X-ray studies of the kidneys and ureters in diagnosing abdominal tumors, both intrinsic and extrinsic to the urinary system.

Diagnostic Errors

Among the diagnostic errors referred to above, I wish to cite the following: 1) In which right hydronephrosis was encountered in an operation for an acute appendix. 2) In which a resection of the cecum was performed because a hydronephrotic kidney caused a compression deformity on barium enema. 3) In which a kidney tumor was encountered when the planned operation was splenectomy. 4) In which adrenal cyst was mistaken for syphilitic spleen. 5) In which ectopic kidney was encountered in an operation for ovarian cyst. Incidentally, probably the most frequent operation for nephroptosis is appendectomy.

It is well at this point to remind you that the nerve supply of the urinary system is so intimately associated with that of the abdominal viscera, that referred symptoms of a reflex nature may appear to arise from pathology of the stomach, intestines, gall bladder, appendix, spleen, pancreas or elsewhere, when actually the pathology is urinary. Digestive symptoms of nausea, vomiting and ileus are commonly caused by a ureteral stone and not infrequently patients have been operated on for mechanical intestinal obstruction for this condition. Fluid levels in the small intestine, at one time thought to be pathognomonic of mechanical obstruction, may appear on X-ray from a paralytic type of ileus. Pain in the testis might occur from low ureteral stone. Pain in the region of the gall bladder or appendix commonly results from right kidney or right ureteral pathology.

It must be remembered that two bodies cannot occupy the same space at the same time, and that when there is enlargement of one organ, or the development of a new tumor within the abdominal cavity it will compress or displace the adjacent organ, sometimes both.[1] (Brown, S.: Differential diagnosis of abdominal tumors by roentgen method, New York State J. Med. 48:609 (March 15) 1948.)

Normal Anatomy

One must be quite familiar with the normal constant relationship of the abdominal viscera, remembering which are mobile and which are fixed. The relatively immobile structures are the liver, spleen, kidneys and pancreas, whereas the stomach and intestines are relatively mobile. It must be kept in mind that the right kidney is adjacent to the liver, the suprarenal glands, the colon and duodenum. The left kidney topography involves the suprarenal, the stomach, spleen, pancreas, jejunum and colon. Although the kidneys are not entirely immobile, there are departures from the normal mobility that are diagnostic of pathology in the kidneys or neighboring viscera. Again one should keep in mind that the kidneys, ureters and bladder are retroperitoneal in contradistinction to the intraperitoneal position of other abdominal viscera.

X-ray studies of the urinary system provide us with a means of greatly enhancing our diagnostic accuracy. They also materially contribute to the diagnosis of abdominal or retroperitoneal tumors extrinsic to the urinary system. Intravenous urograms first came into being about 1922, with the injection of sodium iodide, and it was about 1930 that the organic iodides that we use today became popularized. Excretion studies are of great value in the presence of abdominal tumors, but frequently a retrograde study is necessary, especially for oblique or lateral views.

The accompanying illustrations show urologic pathology commonly misdiagnosed, and

*Drs. Coplan, Woods and Melvin, Miami, Florida.
**Presented at the 1955 KSMA Annual Meeting Sept. 28-30 in Louisville.

also tumor masses arising from outside the urinary tract that displace either the ureter, bladder or kidney.



Fig. 1. NORMAL antero-posterior Pyelo-ureterogram



Fig. 2. NORMAL lateral Pyelogram

Figures one and two represent the normal appearance of the kidneys and ureters in the antero-posterior and in the lateral X-ray views. The right kidney commonly is slightly inferior to the left. The ureters lie close to the tips of the transverse processes of the lumbar vertebrae and curve around the sacrum, where they approach the posterior inferior portion of the bladder.

In the lateral view it may be seen that the kidney lies in the same plane as the vertebrae and the ureter approaches the kidney directly from the anterior portion of the first sacral vertebra. This position is assumed by the right kidney when the patient lies on his right side, and by the left kidney when he lies on the left side. The superior kidney commonly falls slightly to the anterior. The most satisfactory lateral pyelograms are obtained with catheters in one or both kidneys while injecting a contrast medium to one kidney at a time. Intravenous X-ray studies are not as satisfactory because there may be confusion in identifying the kidneys, and the ureters are more clearly identified when a ureteral catheter is indwelling.

Examples of Abnormalities



Fig. 3. Solitary cyst of the left kidney

Figure three shows the classical "saddle" type of kidney pelvis riding the superior surface of a large solitary cyst of the kidney.

In figure four there is obvious lateral displacement of the upper one-third of the left ureter. This displacement was caused by para-



Fig. 4. Displaced ureter caused by metastasis to the para-aortic lymph nodes from a carcinoma of the left testis.

aortic lymph nodes involved in metastasis of a left testicular tumor. The primary tumor was discovered after seeing the X-rays, having been missed on the original physical examination.



Fig. 5. Left ureter displaced by a neuroblastoma.

Figure five shows a similar displacement of the upper one-third of the left ureter caused by a neuroblastoma in a child. The excretory urogram did not show the ureter and was of no value in locating the tumor in an obvious retroperitoneal location.



Fig. 6. Left kidney displaced across the midline by the spleen and nodes in leukemia.

Figure six reveals the left kidney displaced across the midline by enlarged lymph nodes and a large spleen in a patient with leukemia. Under X-ray therapy the spleen and nodes re-



Fig. 7. Tubercular cold abscess displacing the right kidney superiorly.

gressed and the kidney resumed its normal position.

Figure seven shows superior displacement and torsion of the right kidney caused by a cold tubercular abscess.



Fig. 8. Left adrenal cyst depressing the left kidney.

Figure eight shows inferior displacement of the left kidney caused by an adrenal cyst which subsequently hemorrhaged, resulting in the patient's death. The mass receded under antiluetic therapy and had been misdiagnosed as syphilitic spleen. Retroperitoneal insufflation and angiographic studies would most likely have demonstrated this to be retroperitoneal, and not an enlarged spleen.



Fig. 9. Retroperitoneal lipoma displacing the right ureter anteriorly. Lateral view.

Figure nine is a lateral view demonstrating an anterior displacement of the ureter produced by a "so-called" retroperitoneal lipoma.



Fig. 10. Abdominal aortic aneurysm.

Figure ten reveals the calcium deposit in the wall of an aneurysm of the abdominal aorta. This is not an uncommon finding on urologic X-rays and many times is unsuspected.

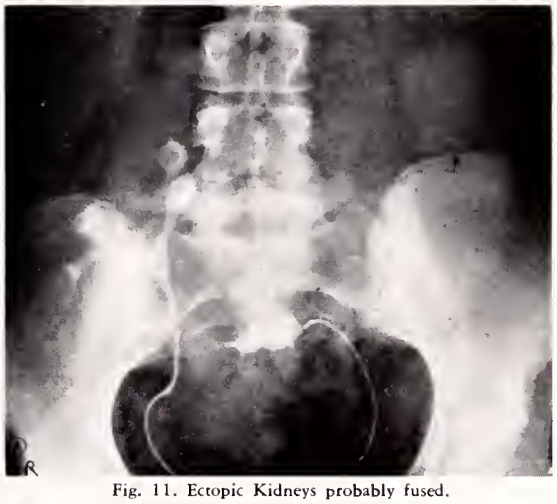


Fig. 11. Ectopic Kidneys probably fused.

Figure eleven shows ectopic kidneys which

sometimes may be palpated on vaginal or bimanual examination and can easily be mistaken for an ovarian cyst or other pelvic tumor.

Summary and Conclusion

In summary, several conditions causing abdominal masses have been presented. Displacement of various parts of the urinary tract have been demonstrated by intrinsic and extrinsic pathologic conditions.

The three dimensional urologic X-rays will divulge much valuable information whenever an abdominal mass is encountered at physical examination.

EVALUATION OF VAGOTOMY AND PYLOROPLASTY IN THE TREATMENT OF DUODENAL ULCER*

Howard E. Dorton, M.D.**
Lexington

REGARDLESS of which method of treatment one recommends for duodenal ulcer, all are in agreement that the success of any form of treatment, medical or surgical, depends almost entirely upon the degree of control of the acidity of the gastric juice.

Dragstedt,[1] in 1943, presented work which showed that, at night, while at rest, the normal individual produces about a pint of normal strength gastric juice, whereas the ulcer patient produces upwards of a quart or more of strongly corrosive juice. He found, as did Pavlov and others, that division of the vagus nerves stopped this abnormality every time. Return to normal of volume and strength of gastric juice was associated with healing of duodenal ulcer in almost every instance.

The effect of vagotomy, on the secretion of gastric juice, Dragstedt found to be permanent. Patients tested as long as seven years following vagotomy showed the same low acid values as those obtained immediately postoperatively.

The reasonableness of his findings and the simplicity of the operation persuaded us to make this clinical trial which was started in late 1946. Since then we have performed vagotomy and a drainage procedure 151 times.

Shortly after beginning our study we found, as did others, [2, 3] that after simple vagotomy, symptoms of mechanical pyloric obstruction would sometimes develop and be troublesome. This was due to the temporary paresis of the stomach which occurs after vagotomy. Also the fixed distortion and narrowing of the area could not be expected to be altered by simple vagotomy. In order to overcome this, a drainage procedure was added to the technique.

We chose pyloroplasty as the procedure we would use, if technically possible, because it would allow us to confirm our diagnosis, remove the scarred area and then restore the anatomy to a more natural state. Also pyloroplasty seemed less likely to interfere with normal digestive processes. In addition, pyloroplasty alone, seldom if ever will cure duodenal ulcer and so we felt we could better evaluate the pure effects of vagotomy. There are, of course, other advantages of pyloroplasty over gastroenterostomy which entered into our decision, such as ease of performance, and avoidance of the inherent complications of gastroenterostomy. Also since pylorospasm has been considered to be one of the contributing factors in the cause of duodenal ulcer, we thought that division of the pyloric sphincter would be a simple way of eliminating this factor.

Technique

At operation, the diagnosis is first confirmed by careful inspection of the region or if necessary by opening the pylorus and first part of the duodenum. Subphrenic vagotomy is then performed, being extremely careful not to overlook any stray branches. It is easier to do a complete vagotomy if the esophagus is drawn well down into the abdomen so as to get at the two main vagus trunks rather than at the arborizations further down. With a little practice this part of the procedure can be done in a very few minutes. We seldom find it necessary to reflect the liver or to tie the cut ends of the

*Presented before the meeting of the Kentucky State Medical Association, Louisville, Kentucky, September 8, 1955.

**From the Surgical Group of Dorton, Webb, Hyden, and Moore.

nerves. Dragstedt has proved to our satisfaction that even simple crushing of the nerves is sufficient to produce permanent interruption.

Our attention then turns to the drainage problem. In all but five of our cases we have been able to perform pyloroplasty of one type or another. The simplest type is the Judd or Mikulicz pyloroplasty. It has been used 125 times and consists of a linear incision of the pyloroduodenal junction so that two fingers can be inserted easily down into the duodenum and up into the stomach. The ulcerated area is trimmed away and the opening is closed transversely. We have found that a neat closure is almost always followed by a smooth convalescence and a good result. Rough handling or inversion of too much tissue is very likely to interfere with drainage and jeopardize the result. The procedure can sometimes be made easier by mobilizing the second portion of the duodenum by the method of Kocher.

When the ulcer is located on the posterior-superior or the posterior-inferior duodenal wall the area is wedged out as illustrated (fig. 1). The resulting V-shaped defect is closed side to side and the remainder of the closure is the same as for simple anterior-pyloroplasty. This has been used 14 times in this group. Sometimes the duodenum is so distorted or the ulcer situated so deeply in the head of the pancreas that it cannot be removed by the simpler procedures described above. In these we cut across the duodenum just distal to the area and across the pylorus just proximal to the sphincter and discard the intervening unhealthy tissue. The stomach is then joined to the open end of the duodenum in a simple end-to-end anastomosis as in the Bilroth I operation. An anastomotic leak in one of our early cases has caused us to wrap a tongue of omentum loosely but completely around all such Bilroth I type anastomoses. This reinforcement is most important. We have used this procedure seven times in this series.

In certain cases the ulcer may be so near the common duct or the inflammatory process so

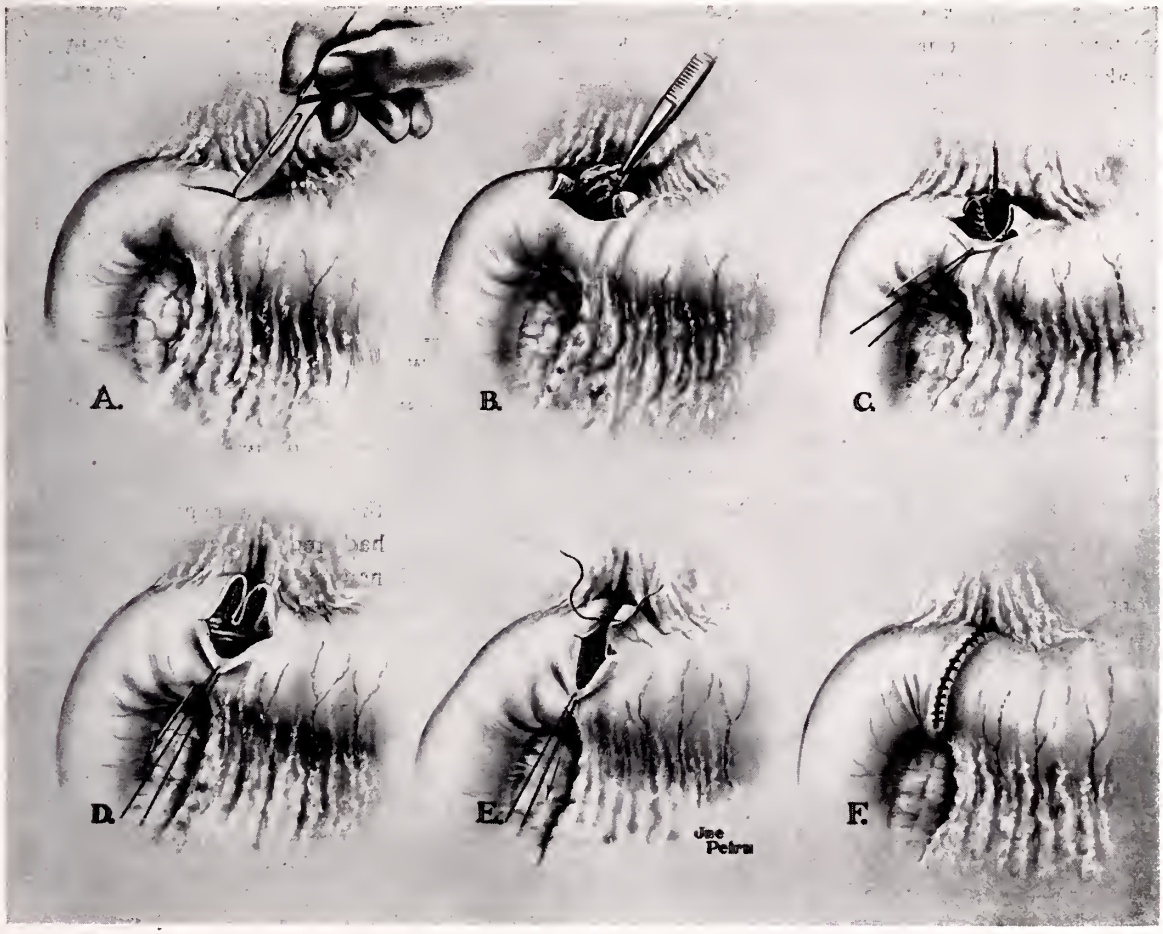


Figure 1. Wedge pyloroplasty. Author's method of removing an ulcer situated on the posterior-superior duodenal wall.

extensive that direct attack might do more harm than good. In these cases a short loop posterior gastroenterostomy was performed, placing the stoma near to the pylorus along its greater curvature to provide the best possible arrangement for drainage. We had to resort to gastroenterostomy in only five of the 151 cases.

Postoperative Care

Before surgery was performed the physiological basis for the operation together with an explanation of the temporary gastric atony which he could expect was given to the patient. With this understanding the patient became a partner in what was to be done to hasten his convalescense. All oral intake was restricted until normal intestinal peristalsis had returned, usually by the third day. Then small amounts of tap water, usually an ounce an hour, were given and the volume was increased to two, and then three ounces per hour during successive four hour periods. The next morning, if the water had been well tolerated he was given six, small, soft, bland feedings to be chewed thoroughly. Fluids of any sort were still restricted to three ounces per hour. After each intake of any sort the patient was asked to rest on his right side for 15 or 20 minutes to allow gravity to assist in emptying the stomach content into the duodenum where active peristalsis could pick it up and pass it on down the digestive tract. If at any time a sense of fullness existed at the time a feeding was due all intake was postponed until this subsided, even if it required a 12 or 24 hour fast. The frequent interval feeding program was continued for about two weeks, at which time those feedings occurring at regular meal times were gradually increased, and the others were diminished. By the end of a month the patient had usually graduated himself to three modest regular meals daily. At this point all dietary restrictions were removed except to caution against overeating. Also he was advised that all foods be thoroughly chewed, and to rest on his side after meals for a short time if possible.

Those of our patients who adhered to the above outlined program had very few digestive difficulties. Occasionally we failed to make clear to a patient or his attendants the importance of adhering closely to the foregoing feeding schedule. As a result in a few instances intake was allowed to exceed output. The decomposition of the stagnant gastric content then caused the foul eructations and fermentative diarrheas that were reported frequently in the very early experiences with plain vagotomy.

As stated before, this retention phenomenon can be avoided by careful planning but if it does occur it can usually be overcome promptly by emptying the stomach completely, and after a 12 to 24 hour rest period, resuming the feeding program prescribed immediately postoperatively. It is not necessary, in most instances, to use a gastric tube. The patient's stomach usually can be emptied by self-induced gagging after ingestion of a quantity of baking soda-water. Urecholine® or other smooth muscle stimulants usually are not required to correct the situation. Once the stomach is emptied the secondary diarrhea stops. Persistent diarrhea can be controlled by giving any one of the intestinal antibiotics.

General Statistics

Analysis of the 146 cases (table 1) on which vagotomy and pyloroplasty was performed showed that 124 were males. The average age was 43.5 years, the youngest being a 10 year old boy and the oldest a negro man of 75, whose ulcer had recently perforated. There were only 12 negroes in the group. The average time elapsed since operation in the entire group of 146 patients was 3.3 years. Thirty-one patients in the group were operated on during the past 18 months and so, are very short term follow-ups.

Table 1

146 DUODENAL ULCER PATIENTS
Males—124 Females—22 White—134 Colored—12
Average Age—43.5 years Youngest—10 Oldest—75
Average Duration of Symptoms Preoperatively—11 years
Average Duration of Follow-Up (1946-1955) 3.3 years
(31 Patients—18 Months or Less Postoperatively)
Average Postoperative Hospital Stay—8.1 Days

The average duration of symptoms before surgery was 11 years. Previous perforation of the ulcer had occurred in 19 patients (table 2). Symptoms of obstruction were present in 45 patients. Obstruction was almost complete in 13 of these. Back pain and night pain were

Table 2
Analysis of Symptoms—146 Duodenal Ulcer Patients

SYMPTOMS	NUMBER OF PATIENTS
Previous Perforation	19
Significant Obstruction (Almost Comp. in 13)	45
Bleeding: History of Hematemesis or Melena .....15; Requiring Hospitalization, Blood .....17; Continuing Massive, Emergency Operation 10	42
Back Pain, Night Pain	36

prominent in 36 patients and practically always indicated penetration of an ulcer into the pancreas. Bleeding of significance occurred in 42 patients. Of these, 15 had had an occasional definite tarry stool or hematemesis which had not been severe. Seventeen had bled enough to require hospitalization and transfusions, and 10 had massive continuing hemorrhage requiring surgery for control. We have included these patients who had massive bleeding in this report even though they are usually made the subject of a separate report since they present special problems and usually carry a much higher morbidity and mortality rate.

The follow-up information on our patients has been obtained by personal interview, questionnaire, and by personal communication with the family physician in some cases. The criteria for evaluation of our results were as follows:

EXCELLENT: Free of all ulcer type symptoms or objective evidence of ulcer while on unrestricted diet and without medications. Side effects absent or very mild. Usual occupation.

GOOD: Free of ulcer symptoms or objective evidence of ulcer, but moderate persistent side effects of some type, which were not seriously disturbing. Works practically full time.

IMPROVED: Still partly incapacitated (side effects, weakness, nervousness, etc.) but no ulcer pain and no objective evidence of recurrent ulcer. Patient himself feels he is definitely improved.

POOR OR FAILURE: Definite persistent ulcer type pain, or proved recurrent ulcer. Incapacitating side effects. Reoperation necessitated to revise the original procedure.

Results

The operative mortality for this group of 146 patients was 1.4 per cent which compares very favorably with the national average (table 3). The first of our two deaths occurred in a 66 year old man who was extremely depleted preoperatively from prolonged complete pyloric obstruction. He died on the ninth postoperative day apparently from progressive cardiac failure. Autopsy was not performed. The second death occurred on the fourth postoperative day. The patient was a 24 year old colored male who was operated upon for massive bleeding. Autopsy showed the cause of death to be extensive mesenteric thrombosis. There had been no further bleeding.

Table 3
Analysis of Vagotomy and Pyloroplasty Failures

REASON FOR FAILURE	PATIENTS
Probable Persistence or Recurrence	5
Re-operation—Persistent Ulcer Found	3
Re-operation—No Ulcer or Obstruction Found	3
Deaths— 66 Year Old White Male with Prolonged Complete Obstruction; 24 Year Old Colored Male Emergency Operation for Massive Bleeding	2

Eleven of our results we have classed as failures although six of them have responded well to further surgery. These six we have operated on again because of symptoms and x-ray findings suggestive of persistence of ulcer. Three of these did have persistent posterior wall ulcers that had not been removed at the original operation. We performed small gastric resections (50 per cent) on two of these. The third patient had such extensive periduodenal inflammatory reaction that only a dependent gastroenterostomy was performed. All three of these now have very satisfactory results. Incidentally, these persistent posterior ulcers have led us to believe that whenever possible the ulcer should be removed at the time of pyloroplasty and led us to develop the wedge operation and to use the Bilroth 1 type limited removal of the pylorus and first part of the duodenum in order to eradicate deep craters in the posterior wall. The other three

ACHROMYCIN

Tetracycline *Lederle*

in the treatment of

infections in surgery

The prevention and control of cellulitis, abscess formation, and generalized sepsis has become commonplace technique in surgery since ACHROMYCIN has been available. Leading investigators have documented such findings in the literature.

For example, Albertson and Trout[1] have reported successful results with tetracycline (ACHROMYCIN) in diverticulitis, gangrene of the gall bladder, tubo-ovarian abscess, and retropharyngeal abscess. Prigot and his associates[2] used tetracycline in successfully treating patients with subcutaneous abscesses, cellulitis, carbuncles, infected lacerations, and other conditions.

As a prophylactic and as a therapeutic, ACHROMYCIN has shown its great worth to surgeons, as well as to internists, obstetricians, and physicians in every branch of medicine. This modern antibiotic offers rapid diffusion and penetration, quick development of effective blood levels, prompt control over a wide range of organisms, minimal side effects. There are 21 dosage forms to suit every need, every patient, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Broad-range antibiotic action to fight infection; important vitamins to help speed normal recovery. In *dry-filled, sealed* capsules for rapid and complete absorption, elimination of aftertaste.



dry-filled sealed capsules

[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

Lederle

LEDERLE LABORATORIES DIVISION

AMERICAN CYANAMID COMPANY

PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

PHOTO DATA: AERIAL CAMERA WITH K-2 FILTER AT DUSK, F.11, 4/100 SEC., FAST PAN FILM



ACHROMYCIN ACHROMYCIN

who required more surgery showed their ulcers to be well healed and nothing could be found to account for their symptoms. What had been thought to be penetrating ulcer on x-ray was the pseudo-diverticulum formation secondary to the pyloroplasty.[4] They now have satisfactory results, although for this purpose they are classed as failures.

All six of the re-operations occurred in the early part of this experience. At the present time we do not rely too heavily on x-ray evidence postoperatively after pyloroplasty because of the pseudo-diverticuli which may be formed by the procedure. It is only when the patient has a recurrence of typical ulcer symptoms such as he had preoperatively that we definitely diagnose a recurrence.

The other five of our patients in the failure group have had a recurrence of typical ulcer symptoms and are being managed fairly well on medical treatment. All had posterior wall ulcers which were not removed, and in which anterior or Judd pyloroplasty was done. Recurrent symptoms appeared a short time after surgery.

Table 4
Complications Following Vagotomy and Pyloroplasty in 146 Patients

Gastric Retention—3 to 6 days	11 Patients
Wound disruption	1 patient
Anastomotic leak	1 patient
Postoperative hemorrhage	1 patient
Dysphagia, two to three weeks	7 patients
Hernia, incisional	1 patient

Of the remaining 133 patients (91 per cent) (table 4), six are classified as being improved, nineteen as having obtained a good result, and 108 as being entirely well. This compares very favorably with results reported nationally[5].

Complications

The surgical complications have been relatively few (table 5). Mild to moderate gastric retention during the immediate postoperative period occurred in eleven patients. This complication seldom occurs anymore since the care of the temporarily atonic stomach has been better understood. Wound disruption occurred in one case, an obese asthmatic male. A small

Table 5
Results of Vagotomy and Pyloroplasty in 146 Patients with Duodenal Ulcer 1946—1955

RESULTS	NUMBER OF PATIENTS	PER CENT	
Excellent	108	73.9%	91.0%
Good	19	13.0%	
Improved	6	4.1%	
Poor or Failure	11	7.6%	7.6%
Deaths	2	1.4%	1.4%
Total	146	100.0%	100.0%

posterior leak developed in one of the Bilroth I anastomoses. A few days later the same patient had a severe hemorrhage for which emergency surgery was required. A large vessel in the bottom of the fistulous tract was found to be the source of the bleeding. After this episode the duodenal fistula healed spontaneously and the patient made an excellent recovery. Dysphagia occurred in seven patients and lasted for two or three weeks. This is apparently the result of handling the lower end of the esophagus. We have recently found that giving an ounce of one per cent Novocain® a few minutes before meal time will cause dysphagia of this type to disappear after one or two such treatments.

We were somewhat surprised to find that eight of these patients (5.4 per cent) complained of symptoms suggestive of the dumping syndrome. All of these were fairly mild and lasted only a few months.

The effect of the procedure on the patient's weight was very encouraging (table 6). Eighty-four patients gained an average of 18 pounds; 38 patients retained their original weight; and 24 patients lost an average of 12 pounds. A few of these were on a weight reduction program.

Untoward gastrointestinal symptoms seldom

Table 6
Weight Record Following Vagotomy and Pyloroplasty in 146 Patients

Gained average of 18 pounds	84
Remained same weight	38
Lost average of 12 pounds	24

present themselves after the second or third postoperative month. During this time, however, while the stomach is regaining its tone the patient may complain of a moderate amount of gas and occasional diarrhea. More frequently he may have vague subumbilical crampy pains which we have interpreted as being akin to the irritable bowel syndrome. At any rate, they are nearly always relieved by a short period on a bland diet and antispasmodic medication. A few patients note that on arising they regurgitate greenish yellow fluid which is disagreeable. This, of course, is due to the free access which bile now has to the stomach and can be alleviated by having the patient drink fruit juice. Sleeping on the right side also seems to help. This bile regurgitation is transient, seldom persisting more than a few weeks.

We have not noted any recurrence or persistence of ulceration since we have been removing the ulcer or excluding it from the gastrointestinal tract. We feel that this may be an important feature of the treatment even though it does require a bit more surgery and does increase the risk somewhat. As stated before, there are certain cases in which an ulcer may be so deeply situated and inflamed in an obese poor risk patient, that no attempt should be made to attack the ulcer proper. In these, a dependent gastroenterostomy is done as a second choice procedure. Perhaps we have been overzealous in employing the number of pyloroplasties that we have and should resort to gastroenterostomy more often. The bleeding ulcer should definitely be removed and we have further protected the duodenum from the head of the pancreas by wrapping a tongue of omentum around the line of anastomosis.

Summary

1. One hundred fifty-one cases of vagotomy and drainage procedure for duodenal ulcer are reported.
2. Pyloroplasty was the drainage operation in 146 cases.
3. Satisfactory results were obtained in 91 per cent of the cases.
4. The average hospital stay following surgery was a little over eight days.
5. The effect of the procedure on the patient's weight was very encouraging. Eighty-four patients gained an average of 18 pounds; 38 patients retained their original weight; and 24 patients lost an average of 12 pounds. A few of these were on weight reduction programs.
6. There were two deaths in 151 patients, a mortality rate of 1.3 per cent.
7. Vagotomy and pyloroplasty is a newer procedure than gastric resection. We have had to learn both technique and postoperative management. In view of this we feel that the showing made, in this, our first complete report, can be considered quite respectable.

Conclusions

1. Vagotomy and pyloroplasty, in our hands, has proved to be a satisfactory method of treating nearly all types of complicated duodenal ulcer.
2. Bleeding ulcer is amenable to the same treatment provided the ulcer is removed.
3. Our ability to eliminate side effects appeared to be directly proportional to our ability to restore the pyloroduodenal outlet to as near normal size and contour as possible.
4. Once a patient has obtained a good result from the operation he usually remains well.
5. The patient who is well following vagotomy and pyloroplasty is completely well and can lead a perfectly normal life as far as his previous disease is concerned.
6. Since the operation appears to be based upon sound physiologic principles and has yielded very satisfactory clinical results we feel that it should be given strong consideration whenever a duodenal ulcer patient is being considered for surgery.

References

1. Thornton, T. F., Jr., Storer, E. H. and Dragstedt, L. R.: Supradiaphragmatic Section of the Vagus Nerves. JAMA 130: 764-771, 1946.
2. Gardner, C. E., and Hart, D.: The Surgical Treatment of Peptic Ulcer. Ann Surg. 127-1056-1066, 1948.
3. Dragstedt, L. R., and Camp, E. H.: Follow-up of Gastric Vagotomy Alone in the Treatment of Peptic Ulcer. Gastroenterology 11:460-465, 1948.
4. Dorton, Howard E., and Webb, J. G.: Vagotomy and Pyloroplasty, the Physiologic Treatment for Duodenal Ulcer. KSMJ (April) 1951.
5. Grimson, K. S.: Surgical Procedures for Peptic Ulcer: A Critique of the Committee Report, Gastroenterology 24:275-280 (June) 1953.
6. Dorton, H. E., Webb, J. G., and Royalty, D. M.: Vagotomy and Pyloroplasty—A Simple Safe Solution to the Bleeding Ulcer Problem.

THE RESIDUAL TUBERCULOUS DISEASE AFTER CHEMOTHERAPY*

E. M. Medlar, M.D.
Ithaca, New York

CHEMOTHERAPY in tuberculosis has been conceived on numerous occasions, but up to 1945 all such pregnancies have resulted in stillbirths. Today, we have in our midst a lusty adolescent chemotherapeutic progeny. This youngster, during its growth and development, has shown some admirable traits and also some that are not so nice—an occurrence that one naturally expects in the period between birth and adolescence. What the characteristics of the fully matured chemotherapeutic progeny may be, remains to be determined. This afternoon, I would like to review with you some of the features of the remnants of the tuberculous pulmonary disease after an effective course of combined chemotherapy had been in force for four months or longer.

Material

The material on which this study is based came from over 500 tuberculous patients. In large part, the resected tissue came from patients who had done very well clinically and at the time of operation had had a negative sputum or fasting gastric contents for several months. Several in the group had had either a single positive culture or no bacilli had been demonstrated, although numerous cultures of sputum or of fasting gastric contents had been done. In the pre-chemotherapeutic days, all of these cases would have been considered as good clinical results. In the large majority of the cases in this portion of the material, all demonstrable disease was removed and, in several instances, this required resection of tissue from both lungs. The remainder of the cases might be called chemotherapeutic failures because cavities remained open, with and without the presence of tubercle bacilli in the sputum or the sputum had remained positive although at no time was there radiological evidence of cavity formation. In these cases, only the major diseased areas were removed.

It is of interest that in this sizable group of cases, there was one in which the surgeons failed to find any abnormal tissue to remove; that in two the resected abnormal tissue showed only parenchymal scars and no diagnosis of tuberculosis could be made; and that in the remainder, the resected tissue contained easily recognized necrotic lesions that varied greatly in size and in numbers.

In the early part of the study, bacteriological examinations of over 500 necrotic lesions were done with the result that about three-fourths showed well stained tubercle bacilli in smears. The number of bacilli varied greatly with numerous bacilli in about one-third of the lesions. Cultures of the material yielded growth of bacilli in less than 10 per cent of the "closed" lesions, many of which contained large numbers of organisms, and growth was obtained from all open tuberculous cavities. Guinea pig inoculations gave no greater positive results than culture. I have found a similar situation in necrotic tuberculous lesions which have been removed from patients who have had no chemotherapy. It seems quite probable that this peculiar bacteriological phenomenon may not be related to the influence of chemotherapy. This bacteriological problem still remains to be solved. I am of the opinion that it is a waste, both of time and of effort, to pursue the problem further if only the now accepted laboratory technics are used.

In the past, the pathologist's understanding of pulmonary tuberculosis has been gained from necropsies on patients who have died from the disease and usually the study of the diseased lungs has not been thorough enough to unearth the many variations in the pathology that commonly are present. Tuberculous disease found in patients who died from other causes usually has been investigated no further than to make a diagnosis. It is understandable why this situation is present among pathologists. Unless they have a special interest in the complexity of the disease and also have sufficient laboratory assistance to make possible a thorough study, it usually is impossible to do more than to render a correct diagnosis.

The resection of tuberculous lung tissue during a course of chemotherapy places in the hands of pathologists tuberculous disease at a time and under conditions with which they

*Presented at the 1955 KSMA Annual Meeting in Louisville, September 27-29.

have not hitherto had to deal. This, I fully appreciated from the outset of the study. Also, I had come to recognize the variables that may be present in untreated tuberculous disease. As a result, I have been conservative in giving credit to the use of chemotherapeutic agents, unless there was a distinctly different pathological picture than that I knew occurred in unresected disease. Because of the many years I have devoted to an attempt to understand the dynamics of the complicated pathological process that is tuberculosis, the views which I shall express may well be at variance with the several papers which have already appeared in the literature and which have dealt with an interpretation of the effect of chemotherapy on the pathological process.

Illustrative Cases

I learned from the first resected specimen I examined that the clinical history of tuberculous patients had best be ignored. This patient was the first, I believe, to have residual minimal disease resected after a considerable course of combined chemotherapy and it deserves mention of the major clinical features. At age 27, this veteran entered a medical school and a chest X-ray, which was required of all students before being matriculated, showed a small linear shadow in the right apical region. A diagnosis of tuberculosis was made and the young man was advised to enter a tuberculosis hospital for treatment. He was treated on bed rest only for 10 months, during which time there was no change in the roentgenological shadows. Although numerous attempts were made, no tubercle bacilli were found in fasting gastric contents. He was then put on exercise and after about three months on this regimen, his chest X-ray showed a sizable new soft shadow which completely effaced the old lesion. Cultures at this time failed to show tubercle bacilli. He was promptly placed on combined chemotherapy. Within three months, the new shadow had completely disappeared and the original linear shadow seemed somewhat smaller. Radiologically, there was no change during the next five months and after eight months of chemotherapy, the residual disease was resected.

The resected tissue showed considerable parenchymal scarring, the presence of a few small necrotic lesions and a larger lesion that measured eight mm. in diameter. The large lesion was serially sectioned and it was found to contain a small open cavity with a fully patent bronchial communication. Tubercle bacilli were found in the cavity, although they were not numerous. In the serial sectioning, a small, quite firmly calcified focus was encountered. This lesion nicked the knife and nearly ruined the serial sectioning, as well as my disposition. Study of the serial sections showed that the calcified focus was an integral portion of the cavity and that beyond the calcified lesion, there was a much smaller hyalinized necrotic focus that was directly connected with the calcified one.

This sort of a pathological picture clearly indicated that the disease must have been of several years duration at the time it was first discovered. Furthermore, the actual situation would not have been revealed had I been satisfied with a routine examination and a casual section for diagnosis.

A second case of minimal tuberculosis also clearly shows the unreliability of the clinical history as an aid to the understanding of the resected pathology. A high school girl, at age 15, was found to be a reactor to tuberculin during a tuberculin survey of the school. Chest X-ray at the time revealed no disease. X-rays taken twice a year for two years and yearly for two years more showed no abnormal shadows. At age 20, the young lady applied for entrance to a school of nursing and as a part of the routine pre-entrance examination, an X-ray of the chest was taken. This showed sizable shadows in the right upper lung field. A sputum examination at this time was positive for tubercle bacilli. Clinically, it seemed evident that this was a case of "early" minimal pulmonary tuberculosis. Combined chemotherapy was begun promptly and during the next six months, there was some clearing of the roentgenological shadows. However, easily visualized nodular lesions remained and the residual disease was resected.

Examination of the resected tissue showed several sizable necrotic foci and an open small tuberculous cavity with a patent ulcerated bronchial communication. Of particular interest, was the finding, loose within the cavity, of a two mm. densely calcified piece of tissue. This would seem to be the calcific remnant of at least a portion of an initial lesion that, in all probability, dated back for five years and

perhaps longer. Apparently a small smouldering area of disease which was not recognizable in the chest X-ray, sloughed a sufficient amount of material to induce a sizable localized area of new disease and to give rise to a positive sputum.

Findings in Chemotherapy

These two cases have been cited in some detail to indicate how sluggish tuberculous disease may be and also to show how erroneous an impression may be gained from a reliance upon the clinical history of tuberculous patients. This is of prime importance when it comes to an interpretation of the pathological picture found in resected tissues after a considerable course of chemotherapy. Undoubtedly, in most tuberculous cases there are necrotic lesions before chemotherapy is begun and, in many instances, these may be of considerable age. Not infrequently, I have found calcific foci in tissue resected from patients who have had chemotherapy for no longer than six months. Certainly, the calcification and other evidence of healing in the older necrotic lesions can hardly be attributed to the affect of chemotherapy.

One of the clinical features during chemotherapy is the considerable clearing of roentgenographic shadows. This phenomenon, of course, occurred in the pre-chemotherapy era, but it seemed to occur more promptly under chemotherapy. At operation, the surgeon has found, not infrequently, more residual disease than was suspected from the X-ray films, but in several cases much less tissue had to be removed than was anticipated. Examination of resected specimens from these cases always reveals some parenchymal scarring, as well as necrotic foci. However, it would seem that in many, there has been complete resolution of sizable areas of pneumonia with a restoration of normal lung tissue in such areas. It is my impression that the scars in these cases represent the end result of healing of that portion of the non-necrotic component which had proceeded to epithelioid tubercle formation. In my experience, it has been unusual to find epithelioid tubercles in specimens removed after four months or more of combined chemotherapy, unless evidence of sloughing lesions was present. In these latter specimens, early epithelioid tubercles, as well as small patches of lobular pneumonia that probably were not more than a week or two old, were found on several occasions. These findings suggest that small endobronchial disseminations, which were too small to be detected in X-ray films had occurred during the course of chemotherapy.

On a few occasions, I found in the resected specimens small areas in which the alveoli were filled with necrotic debris without there being any cellular inflammatory reaction in the area. These areas appear to represent a spread of necrotic debris during an unavoidable manipulation during surgery. This suggests that chemotherapy should be continued for at least four months after the operation to facilitate a complete healing of these new foci of disease. Lesions of this nature can not be detected macroscopically in the specimen and it is extremely doubtful that they can be recognized by the surgeon.

There was a monotony of necrotic lesions in the resected specimens. These are the lesions which always have been the stumbling block to the complete cure of tuberculosis. These lesions presented a quite variable appearance in their fibrotic peripheral portions. It is my impression that these variations are related more to the age of the lesion than to the effect of chemotherapy. Random sections commonly show the lesions to be completely encapsulated, but this is deceptive. More thorough study of such lesions often shows an open bronchial communication with the necrotic center. On a few occasions I have done complete serial sectioning of a necrotic lesion of a centimeter or more in diameter and in these lesions, the bronchial connection was present in less than half a dozen out of several hundred sections. If the necrotic contents of such lesions undergo liquefaction, it is into this small bronchial branch that the liquefied contents spill and this is the beginning of new spreads of the disease.

One of the most disturbing features found in this study was the variation in the behavior of the necrotic tissue. These lesions could be entirely disregarded if one were sure that liquefaction of the necrotic tissue would not occur. However, not infrequently, microscopic evidence that liquefaction was under way was found in one or more necrotic lesions, even if the individual had been on combined chemotherapy for a year or more. The sloughing of these lesions would be of little consequence if they contained no tubercle bacilli. However,

study has shown that the bacteriological content of necrotic lesions is erratic, both as to numbers and distribution of bacilli, and sometimes the numbers of bacteria are enormous. I have not been able to find evidence to indicate that chemotherapy affects significantly the necrotic tuberculous lesion.

Importance of Cavity

The feature that has always been of greatest concern clincially is the presence of cavity in the tuberculous lung. I would like to suggest that clinicians might well be more concerned about the conditions that precede cavity formations, for a tuberculous cavity simply indicates that an area of necrotic tuberculous pneumonia has, to a greater or lesser extent, been sloughed and spat up. Cavity formation was present in the majority of cases in this study. In the majority of those that came to surgery, the cavity disappeared, as judged from roentgenograms, and in a minority surgery was done to remove a persistent open cavity. Some of the latter had a persistently positive sputum and in some the sputum had been consistently negative for many months.

In the resected specimens, it was always possible to identify the site of the cavity. In most instances, the cavity was filled with necrotic debris and was much smaller than the original open cavity. Commonly, it was possible, by fine wire probe, to demonstrate an open bronchial communication with the pultaceous necrotic center. Much less often there was a sizable scar that identified the area of cavity and in all but one instance, there was found a small unhealed open remnant of the cavity. Such small unhealed remnants of a former sizable cavity could easily be regarded as of no consequence, but in one instance, a large mass of tubercle bacilli was found in such a remnant that was so small it was overlooked macroscopically. This small area was partly lined with stratified squamous epithelium and evidently was near the original bronchial connection with the cavity. This instance is cited to suggest caution in a macroscopic interpretation of what one may find in specimens removed after chemotherapy. The more thorough the microscopic study one does on these specimens, the more cautious one becomes in his interpretations.

The study of resected open cavities showed that, in the majority of instances, they had a thin "wall" and that the inner surface had an irregular mixture of areas of a thin necrotic layer; of granulation tissue that was free from necrotic tissue; of scar tissue with little inflammatory cellular reaction and no epithelial covering; and of limited areas that were covered by stratified squamous epithelium. These must be regarded as unhealed cavities. Frequently, it was difficult to find tubercle bacilli, but on occasion, one could find well stained masses of bacilli in unexpected and unpredictable spots. Such cavities present the picture of a sluggish, old tuberculous cavity that was not unlike old cavities that one used to find before the days of chemotherapy in tuberculous persons who had lived long with their disease.

There is a strong tendency these days to attribute this sort of picture to the healing effect of chemotherapy. In my opinion, chemotherapy has little to do with the healing of these lesions. Rather, the chemotherapeutic effect is to reduce the toxicity of the disease; to slow down the sloughing process; to create an environment that is not conducive to the rapid multiplication of tubercle bacilli; and in these ways, to greatly lessen the danger, if it does not entirely prevent, new spreads of disease. Under these circumstances, the natural healing process of the individual is given time to assert itself.

The perplexing and discouraging feature in these cases is that all the necrotic tissue has not been cleanly sloughed and that tubercle bacilli still remain even after two years or longer of continuous effective combined chemotherapy. There is a strong tendency to regard this situation as due to the development of resistance by the bacilli to the chemotherapeutic agents. However, I have seen instances in which this condition has been present with complete sensitivity of the bacilli to the therapeutic agents. In my opinion, the condition found in these cases is much more subtle and, at the present time, can not be satisfactorily explained. The condition met with in these parenchymal cavities is also found in bronchi that have been the seat of severe necrotic endobronchial tuberculosis.

There was another small group of specimens in which there were sizable thin walled cavities with a smooth, glistening inner surface throughout. At the present time, these

cavities are being called open, healed tuberculous cavities and again this phenomenon is being credited to the healing effect of the chemotherapeutic agents—a feature that had not been noted in the pre-chemotherapeutic era. I have had the opportunity to study six such cases and in each instance it has seemed to me that this condition represents cystic bronchiectasis, rather than tuberculosis. This is not the place to enter into the details that have led me to this conclusion. However, there are a few features which I believe pathologists should bear in mind. First, pathological conditions can be found in tuberculous lungs that have no etiological relationship to tuberculosis. Secondly, today there are many more tuberculous patients being operated upon to remove open cavities. Finally, it requires a most thorough microscopic study not only of the cavity, which usually is the center of interest, but also of the specimen as a whole in order to determine more accurately the actual pathological situation. At this point, I am reminded of a case that showed large, bilateral cavities and was regarded as a case of far advanced tuberculosis for over twenty years, although tubercle bacilli had never been demonstrated. At necropsy, this individual was found to have bilateral cystic bronchiectasis and no evidence of tuberculosis was found.

Summary

From this discussion, it should be evident that in tuberculosis a most complicated pathological process exists and that in this process, the necrotic component represents the dangerous and most difficult process to combat. It is evident that present day chemotherapy has not conquered this phase of the disease. There is no question but that properly administered chemotherapeutic agents are of great benefit in the treatment of the tuberculous patient. However, from all the pathological evidence I have been able to obtain, it is evident that these agents do not do a complete job—the necrotic component of the disease still remains and far too often well staining tubercle bacilli can be demonstrated in these necrotic remnants. Only time will tell what will happen to the tuberculous patients who have had the benefit of chemotherapy and then have had this form of treatment withdrawn. It may well be that the exact situation in these cases can not be determined for many years, even longer than in the days before the use of effective chemotherapeutic agents. Past experience has shown that tuberculosis is a chronic disease with an erratic and unpredictable course. This situation still exists. There will be no quick and easy solution to this problem.

Manuscript Memos

Manuscripts should be submitted in duplicate to the Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month — day of month if weekly — and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The By-laws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The by-laws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.

SPECIAL ARTICLES

REPORT ON THE ELEVENTH NATIONAL CONFERENCE ON RURAL HEALTH

WYATT NORVELL, M.D.

THE Eleventh National Conference on Rural Health, held in Portland, Oregon, March 8, 9, and 10, 1956 was a graphic demonstration of the enthusiasm and down-to-earth interest which has been repeatedly shown by those who are to improve rural health.

The fact that the conference was held in the far Northwest did not deter attendance from 40 states and a larger volume of attendance than any other National conference. The whole theme of the conference concentrated on the old relationship of the family and its physician. Speakers emphasized, over and over, the relationship of the physician as a 'hub' for many rural activities and programs not directly related to health.

One of the better panels presented was moderated by Duane Bowler, manager of the Montana Public Health League. The panelists emphasized the importance of being a personal family physician—one considered a member of the family—one who knows the family secrets and therefore one better able to handle the family's physical and emotional problems in an understanding manner.

Another point brought out at the conference



Wyatt Norvell, M.D., (second from left), New Castle, chairman of the KSMA Committee on Rural Health invites Dwight Murray, M.D., (second from right), Napa California, AMA's newly elected president to attend the Twelfth National Rural Health Conference in Louisville next March 7-9. Listening to the invitation are F. S. Crockett, M.D., West Lafayette, Indiana, chairman of the AMA Council on RH and newly elected AMA vice president, and George Lull, M.D., Chicago, AMA secretary. The picture was taken at the 1956 National RH Conference which was held March 8-10 in Portland, Oregon.

was the fact that the 'forces of conformity' which are stronger in rural areas are both a help and a hindrance to mental health.

Another matter discussed at the conference was the problem of providing facilities to care for the older persons and the chronically ill in rural areas.

It was pleasing to hear the importance of properly supervised nursing homes being accepted as a project by lay-people. The point made in discussing nursing homes was the significance of having these homes privately built, maintained, and operated so as to keep the Federal Government from getting more control of the elderly people.

The principal speaker at the annual dinner was the American Medical Association's president-elect, Dwight Murray, who told the group "Much of the phenomenal medical progress of the past 25 years has been achieved because of the support—both moral and financial—obtained from the general public." He further said that the continued interest of the public in medical affairs will grow as the interest of physicians in matters outside the medical profession increases and he requested that physicians everywhere mix more with their neighbors and share their interests and their projects. The other speaker at the annual banquet was Louis A. Rozzani, president of the California Farm Bureau Federation. Mr. Rozzani, a native-born Italian, related his own story of success and failure as a businessman and farmer, and observed that, "there are always people who want something for nothing and we should stop trying to solve economic problems by magic words, such as 90 per cent parity." He further stated "there are those who try to solve the country's economic problems by taking from those who have and giving it to those who have not. This will solve no one's problems except the Socialists', who have been trying to do that for years."

If the twelfth Annual National Conference of Rural Health to be held in Louisville, March 7, 8, and 9, 1957, is a success, it will be due to the interest shown by the individual physicians of the Kentucky State Medical Association organizing with the Farm Bureau, home demonstration agents, extension service, nursing associations, and all other member organizations of the Kentucky Rural Health Council. Kentucky physicians must not fail in this very worthwhile movement.

THE DISABILITY FREEZE

IN RECENT months many physicians have heard from patients about the disability freeze provision in the social security law. This provision, added to the old-age and survivors insurance program in 1954, permits people who have prolonged total disability to apply to have their social security records frozen for the period of their disability. Thus, the time when they could not work and so had no earnings credited to their social security accounts does not count against them in determining their rights to benefits, nor the amount of benefits which will be payable to them at age 65, or to their families in case they should die.

Before a worker's social security record can be frozen, he has to meet certain work requirements. His social security record up to the time of his disability must show that he was in fact a worker, with a fairly regular and recent work history. In addition, he must be shown to have a medically determinable physical or mental impairment severe enough to keep him from engaging in any substantial gainful activity—one which has existed for more than six months, and is expected to last indefinitely or end in his death.

Securing the Medical Evidence of Disability

The medical evidence needed to establish the nature and severity of the applicant's disability, the date it began, and its prognosis comes from the doctor who has treated the worker and has been confined. A medical report form was designed to assist the physician in furnishing the needed medical evidence and to indicate the nature and extent of clinical detail which would be necessary. It is given to the applicant for the "disability freeze" and he is asked to have it filled out by the physician most familiar with his impairment. The form itself is modeled closely after the medical report used by major life insurance companies in their disability claims work. In adapting it for use in the "freeze" program, the recommendations of

(Continued on Page 631)

EDITORIALS

THE IMPORTANCE OF LEUKOPLAKIA IN ORAL CANCER

KERATOTIC plaques on the lips and leukoplakia of the oral mucosa are essentially the same lesions. On the lips the scales are dry and often have curled up edges. In the mouth lesions they are soft and whitish because of the secretions. Histologically, they are similar and both are consistently associated with the formation of cancer. Each has its own causative agent.

The constant history of leukoplakia existing prior to the tumor formation and the ulcer of cancer is so impressive that the white deposits should be considered precancerous. A few of us have witnessed the actual accretion of carcinoma from a plaque of leukoplakia. In many patients the story is very straightforward and all follow the same pattern, i.e., a small white spot that remained the same in appearance and in size for several months. Slow growth for two to three months and finally a tingle sensation or pricking pain appeared for the first time to announce a small ulcer occupying a greater portion of the white spot. The total time period averages eight to 10 months. A few will occasionally remark of a causal agent.

Pointed questions will often find a repeated stimulus that produces injury in the same area. Sunburn on the lips is a recognized factor. Smoking or chewing or snuff dipping factors are found in practically all of the mouth cancer patients. The ulcer is occasionally in juxtaposition with a carious tooth. Unlike metals used in restorations that make contact to produce cellular changes from electrolysis will finally yield an infiltrate. The mucosal repair mechanism becomes accelerated to meet the continued injury. Eventually the newly formed cells pile up to form a plaque because of over production. In time the basal cells or reproductive layer produce abnormal divisions and bizarre forms that fail to follow the usual pattern of migration toward the surface of the mucosa and form local cell masses that coalesce to invade the submucosa and choke off the blood supply to produce the ulcer. Many cells throughout the base of the plaque may become abnormal more or less at the same time to produce the primary carcinoma with a broad base. A repetitious injury or stimulus in the form of a carcinogenic agent is frequently associated with the site of the leukoplakia as a causal agent. Ask any of the patients with leukoplakia to "light up" thus demonstrating his ritual and fixed smoking habit performance that is often repeated to send the hot tarry smoke stream to bombard the plaque or ulcer area of leukoplakia.

A biopsy (of the leukoplakia) gives a diagnosis "leukoplakia without evidence of invasion." Yet the lesion will promptly recur and continue to grow if it is not completely eradicated and its causal agent removed. The recurrences end in cancer. It is ridiculous to think of cancer as being of recent origin when it has had eight to 10 months of existence in a form that we have treated with casual indifference and little interest. Why not realize that our weakest attack on cancer is the fatal time lag from suspicion to recognition? Many people are informed of the seven danger signals (American Cancer Society) and urged to obtain a diagnosis of the ulcer that will not heal, but few recognize the precious importance of time wasted while watching the silent asymptomatic precourser of cancer.

Why not eradicate the lesions as soon as they appear and seek and find the causal agent? Why not call it precancerous? Why not prevent mouth cancer?

Jesshill Love, M. D.

Opinions expressed in contributions to this Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

TRUSTEE-STAFF RELATIONSHIPS

THE relationship between the trustees and the medical staff of a community hospital has never been clearly defined even by the Joint Accreditation Commission. This is extremely unfortunate since many misunderstandings could be avoided if the duties of each were more clearly understood. Either an overzealous staff or an overzealous board of trustees can be definite liability to a hospital.

In the "Trustee" which is the publication for hospital trustees, there have been several articles which attempted to state the duties of the hospital staff. In order of importance these were:

1. Treatment of the sick and injured
2. Keeping adequate written records
3. Advising Board of Trustees in physical and professional conduct of the hospital
4. Self-government

In still another article of this publication the board of trustees is defined as the governing body of the hospital, and is morally and legally responsible to the citizens of the community to provide adequate facilities for the treatment of the sick and injured.

Under no circumstances should there be any cross-purpose in the relations between the trustees and the staff, but unfortunately the human element often enters the picture and causes disruption of cooperation between these groups. This may be due to personality clashes between a member or members of the board and a member or members of the staff; or it may be due to misinformation received by either group. In any trustee-staff relationship, the hospital administrator holds a very important position since he is frequently the only liaison between the two groups. He is in a position, if he so desires, to highly color his information, and this has been the case in many instances. It is imperative, therefore, that the administrator be a man of high integrity, be emotionally stable, and be endowed with a great deal of diplomacy.

Many small hospitals now have their staffs so organized that they have joint meetings with the board of trustees at regular intervals either of their entire groups or of their executive committees. Personal contact often irons out foreseen difficulties before they become serious problems, and from all indications the staff-board relations in these institutions are much more desirable.

Any break-down in the delicate relations between the business of hospital management and the practice of medicine within the hospitals can only have an adverse effect on the purposes for which these institutions were founded. This can be avoided by a clear understanding of and a respect for the functions of each group by the other and by working in close harmony for the mutual good of the hospital.

Harry C. Denham, M. D.

Selling Sample Racket

A Louisville physician recently received a request from a man in Chicago asking him for drug samples left by detail men. This incident is not a rare one. It could well be the first step in the "selling sample racket."

Sample racketeers make a business of buying samples submitted to physicians by pharmaceutical manufacturers. They operate in one of two ways. First, ask the physician for the drug, probably saying they are for his family or, by writing the requests directly to the pharmaceutical houses and forging a physician's name. Presumably the physician will later be called on and asked to sell the samples.

In an article in the AMA Journal some years ago the following statement appeared: "Any physician who would cooperate in a performance of this type is participating in a distinctly unethical procedure and is lending himself to what is essentially a fraud."

You, as a physician, can put an end to this "pick-up racket." Each time you write to a pharmaceutical house asking for drug samples make sure your request is written on your own stationery and signed in your own handwriting. "The physician who allows himself to become involved with these racketeers," according to the AMA article, "cannot be too severely condemned."

ORGANIZATION SECTION

Four Specialty Groups Name Annual Meeting Speakers

Four more specialty groups have released the names of their guest speakers for the 1956 KSMA Annual Meeting in Louisville September 18-20.

The groups and speakers are: Kentucky Orthopedic Society, J. Otto Lottes, M.D., St. Louis, Missouri; Kentucky Chapter of the American College of Chest Physicians, Paul T. Chapman, M.D., Detroit, Michigan; Kentucky Academy of General Practice, Louis A. Buie, M.D., Rochester, Minnesota and American College of Surgeons, Edgar Burns, M.D., New Orleans, Louisiana.

Dr. Lottes, a graduate of the University of Louisville School of Medicine, received his orthopedic surgery training at the St. Louis Hospital, Barnes Hospital, and Washington University School of Medicine. He is now clinical instructor in orthopedic surgery at Washington University School of Medicine.



Dr. Lottes



Dr. Buie

Dr. Buie, a graduate of the University of Maryland School of Medicine, is an emeritus professor of proctology at the Mayo Foundation Graduate School and a member emeritus of the Mayo Clinic. He is chairman of the AMA's Council on Constitution and By-laws.

Dr. Chapman is a graduate of the University of Cincinnati Medical School. He served a residency in thoracic surgery at Herman Kiefer Hospital. Since 1939 he has served as chief physician and chief of tuberculosis hospitalization and field service for the city of Detroit.



Dr. Chapman

Dr. Burns is a graduate of Northwestern University Medical School. He is professor and chairman of the department of urology at Tulane University Medical School and president of the American Board of Urology.



Dr. Burns

Joseph R. Bustetter, D.D.S., Louisville, will represent the Kentucky State Dental Association at the Annual Meeting. Dr. Bustetter is a member of the faculty of the University of Louisville School of Dentistry. He is past president of the Kentucky Section of the American College of Dentists.

A complete Annual Meeting program will be carried in the August issue of the Journal.

Nine Kentucky MDs Participate in AMA Annual Meeting

Nine KSMA members participated in the scientific program at the one hundred fifth AMA Annual Meeting in Chicago June 11-15.

Three of these—William McDaniel Ewing, M.D., and John Lyford, M.D., of Louisville and Otto Salsbery, M.D., of Covington assisted in the presentation of the special exhibit of fractures.

Laman A. Gray, M.D., Louisville, presented a paper entitled "Pathological Lesions of the Urethra."

Robert Lich, Jr., M.D., Louisville, read a paper on "Renal Biopsy." Dr. Lich also led a general discussion of the exhibits in the section on urology.

W. K. Massie, M.D., Lexington, presented an exhibit entitled "Functional Fixation of Intracapsular Fractures of the Hip."

Everett L. Pirkey, M.D., Louisville, opened a discussion following a talk on "Pitfalls of Translumbar Aortography."

A paper entitled "The Results of Simple Perineal Prostatectomy," was presented by Edward H. Ray, M.D., Lexington.

R. Glen Spurling, M.D., Louisville, opened a discussion on "Whiplash Injuries" in the section on nervous and mental diseases.

MDs Named to Alcoholic Group

Three KSMA members were appointed by Governor Chandler to a new Kentucky Commission on Alcoholism June 6. The commission was created by the 1956 Legislature.

The three physicians named to the seven member commission were: Louis M. Foltz, M.D., Louisville, chairman of the KSMA Committee on Mental Hygiene and Mental Institutions; Gradie Rowntree, M.D., Louisville, past president of the Jefferson County Medical Society and Gant Gaither, M.D., Hopkinsville, KSMA president.

Better Distribution of Physicians in Needy Areas is KSMA Aim

Plans to provide better distribution of medical care to the people of rural Kentucky were discussed by representatives of the Kentucky Physicians Placement Service and the Rural Kentucky Medical Scholarship Fund in Frankfort May 31.

As part of the improved program aimed at getting more physicians into areas most in need of medical care, John Guy Miller, field secretary of the Kentucky State Medical Association, was named field secretary of the two groups. His official task will be to keep in close contact with each beneficiary of the Fund while he is in school and during his hospital training. Then Mr. Miller will be better able to act as a link between needy communities and physicians seeking locations.

"The program is of utmost importance and is sponsored and backed whole-heartedly by the KSMA", Ralph D. Lynn, M.D., Elkton, chairman of the PPS and C. C. Howard, M.D., Glasgow, re-elected chairman of the Fund, said in a joint statement.

The Fund has in operation two scholarship plans. One allows a student to borrow up to $3,200 over a four year period if he agrees to practice in an area approved by the Fund for as many years as he received assistance and make cash repayment of the amount borrowed plus two per cent interest.

The other plan, which was recently put into effect, permits a student to borrow $3,200 if he will agree to practice in one of Kentucky's critical counties for a period of four years. This will automatically wipe out his debt to the Fund. The critical counties are Powell, Martin, Knott, Rockcastle, Magoffin, Elliott, Knox, Cumberland, Leslie and Breathitt.

The Fund awarded scholarships to 13 medical students at the Frankfort meeting. Thus far 87 students have been granted loans. Eighty-two of these were Kentuckians.

Other officers of the Fund besides Dr. Howard are G. L. Simpson, M.D., Greenville, vice-chairman; Russell Teague, M.D., Louisville, treasurer and J. P. Sanford, Louisville, executive secretary. Mr. Sanford succeeds Raymond Dixon, former deputy health commissioner, who left Kentucky to join the United States Public Health Service in Washington, D.C. June 30.

Hospital Accreditation Discussed by AMA House of Delegates

The Joint Commission on Accreditation of Hospitals, foreign medical school graduates, private practice by medical school faculty members were only a few of the topics under serious discussion at the meeting of the AMA House of Delegates at the Annual Meeting in Chicago, June 11-15.

Both KSMA delegates, W. Clark Bailey, M.D., Harlan and W. Vinson Pierce, M.D., Covington were in attendance at all sessions held by the House. Dr. Bailey served on the Reference Committee for Sections and Section Work.

Hospital Accreditation: A report of the Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals was approved by the House of Delegates. The following conclusions were reached:

1. Accreditation of hospitals should be continued.
2. The Joint Commission should maintain its present organizational representation.
3. The Board of Trustees should report annually to the House of Delegates on the activities of the Joint Commission.
4. Physicians should be on the administrative bodies of hospitals.
5. General practice sections in hospitals should be encouraged.
6. Staff meetings required by the Joint Commission are acceptable, but attendance requirements should be set up locally and not by the Commission.
7. The Joint Commission should not concern itself with the number of hospital staffs to which a physician may belong.
8. The Joint Commission is not and should not be punitive.
9. The Joint Commission should publicize the method of appeal to hospitals that fail to receive accreditation.
10. Reports on surveys should be sent to both administrator and chief of staff of hospital.
11. Surveyors should be directly employed and supervised by the Joint Commission.
12. Surveyors should work with both administrator and staff.
13. New surveyors should receive better indoctrination.
14. Blue Cross and other associations should be requested not to suspend full benefits to non-accredited hospitals until those so requesting have been inspected.
15. The AMA should conduct an educational campain for doctors relative to the functions and operations of the Joint Commission.
16. The Committee also suggests that the AMA and the American Hospital Association encourage educational meetings for hospital boards of trustees and administrators either on state or national levels to acquaint these bodies with the functions of accreditation.
17. This Committee asks to be discharged upon submission of this report to the House of Delegates.

The following statement was added to the report.

The Committee recommends that the commissioners to the Joint Commission on Accreditation of Hospitals, appointed by the Board of Trustees of the AMA urge that Commission to study:

1. The problems of the exclusion from hospitals and arbitrary limitation of the hospital privileges of the general practitioner, and

2. Methods whereby the following stated principles may be achieved;

The privileges of each member of the medical staff shall be determined on the basis of professional qualifications and demonstrated ability.

Personnel of each service or department shall be qualified by training and demonstrate competence, and shall be granted privileges commensurate with their individual abilities.

Graduates of Foreign Medical Schools: The House of Delegates approved a plan to establish a central administrative organization to evaluate the medical credentials of foreign trained physicians desiring to serve as interns or residents in American hospitals.

Private Practice by Med. School Faculty Members: Another major action by the House involved the problem of private practice by medical school faculty members. The House adopted a report by the Council on Medical Service which stated "that it shall be the policy of the AMA that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and the initial disposition of fees for medical service from paying patients should be under the direct control of the doctor or doctors rendering the service."

Federal Aid to Medical Schools: The House voted to support S. 1323, a bill in Congress providing for one-time, matching grants to medical schools for construction purposes.

Premature Drug Publicity: The House adopted a substitute resolution providing that the "drug manufacturer and the medical profession develop cooper-

atively guiding principles which will protect the American people from being subjected to the premature release of information pertaining to new products or techniques."

Complete coverage of all actions and resolutions will be published in the Journal of the American Medical Association. Questions on specific topics discussed by the House will be answered by writing to: George Lull, M.D., Secretary—General Manager, AMA, 535 N. Dearborn, Chicago.

David Allman Is President-elect of American Medical Assn.

David Bacherach Allman, M.D., Atlantic City, New Jersey, was elected president-elect of the American Medical Association at the annual meeting in Chicago, June 14.



Dr. Allman

Dr. Allman, a surgeon, has been on the AMA's Board of Trustees since 1951. He is also chairman of the Association's Committee on Legislation. Hugh Hussey, M.D., Washington, D. C., was elected a trustee to fill Dr. Allman's place.

F. S. Crockett, M.D., West Lafayette, Indiana, chairman of the AMA's Council on Rural Health, was named vice president. Both George F. Lull, M.D., Chicago, AMA secretary and J. J. Moore, M.D., Chicago, AMA treasurer were re-elected.

E. Vincent Askey, M.D., Los Angeles and Louis Orr, M.D., Orlando, Florida, were re-elected speaker and vice speaker, respectively, of the House of Delegates. Julian Price, M.D., Florence, South Carolina, was re-elected to the position of AMA trustee.

Robertson Ward, M.D., San Francisco, succeeds Walter F. Donaldson, M.D., Pittsburgh, as a member of the Judicial Council. Dr. Donaldson is retired.

G. Y. Graves, M.D., Honored in Chicago; Makes Talk

G. Y. Graves, M.D., Bowling Green, KSMA president in 1953, was installed as president of The Conference of Presidents and Other Officers of State Medical Associations on the eve of the AMA's Annual Meeting in Chicago. The conference is not officially connected with the AMA.

Before his inauguration Dr. Graves spoke to an audience of approximately 500 physicians. In his talk entitled "The Medical Practitioner-Yesterday, Today, Tomorrow", Dr. Graves said much has been done and is being done to furnish better medical care to persons in smaller communities. In talking of medicine for the future he said, "We will learn to speak a language that the layman understands. We will try to satisfy all the medical needs that society can legitimately demand."

Dr. Graves is a 1925 graduate of the Vanderbilt University School of Medicine. He is a general surgeon.

Due to unforeseen difficulties it was not possible to have a Case Discussion in this issue of the Journal. The section will be carried in the August Journal.

118 KSMA Members Attend '56 AMA Annual Meeting

One hundred and eighteen KSMA members were registered during the AMA Annual Meeting in Chicago, June 11-15, according to the AMA's Daily Bulletin. Alphabetically, according to dates they were:

Sunday, June 10
Harry Grossman, Ft. Campbell; William P. Hall, Paducah; W. K. Massie, Lexington; David Neustadt, Louisville; J. Vernon Pace, Paducah; I. B. Perlstein, Louisville; Stanley T. Simmons, Louisville; and Frank L. Yarbrough.

Monday, June 11
Charles Baron, Covington; John Bate, Louisville; O. G. Beatty, Louisville; Charles Bryant, Louisville; William Howard Bryant, Glasgow; Irvin L. Carlton, Hazard; Henry B. Caudill, Lawrenceburg; Armand Cohen, Louisville; David L. Deutsch, Fort Knox; James Freeman, Dawson Springs; G. N. Graves, Bowling Green; Michael M. Hall, Campbellsville; Paul E. Holbrook, Ashland; Anne H. Hopwood, Owensboro; Elmo K. Hughes, Louisville; R. B. Jasper, Somerset; O. R. Jensen, Ft. Knox; R. D. Joplin, Louisville; David L. Jones, Fulton; Karl C. Kelty, Lexington; Howard Kopping, Lexington; Joseph Krakauer, Middlesboro; James Kussy, Ft. Campbell; Lloyd Larsen, Lexington; K. L. Lockwood, Outwood; Oscar O. Miller, Louisville; J. E. McKinney, Maysville; Ralph L. Odley, Lexington; Everett Pirkey, Louisville; Edsel Reed, Harlan; Ben A. Reid, Louisville; William G. Rinehart, Pittsburgh; Jane B. Sears, Lexington; Kenneth L. Sears, Lexington; G. N. Schuhmann, Louisville; Elmer Smith, Somerset; Joseph Stoeckinger, Lexington; Robert Stout, Fort Campbell; Herbert Wald, Louisville; and Leslie Winans, Ashland.

Monday afternoon, June 11
R. Glen Boles, Louisville; Paul Bryan, Ashland; Robert Bushart, Fulton; D. H. Erkiletian, Hopkinsville; Gant Gaither, Hopkinsville; Laman Gray, Louisville; Raymond Heitz, Louisville; Arthur Hurst, Louisville; V. A. Jackson, Clinton; A. Clayton McCarty, Louisville; Carlisle Morse, Louisville; David R. Nagle, Lexington; Earl P. Oliver, Scottsville; Gradie R. Rowntree, Louisville; Marjorie Rowntree, Louisville; Russell Rudd, Fulton; John Samuels, Hickman; Frances Sherman, Martin; John J. Sherman, Martin; Leonard J. Singerman, Louisville; Sonne Lohis, Louisville; Lillian H. South, Louisville; Richard C. Spear, Louisville; Charles Stacy, Pineville; Richard Thurm, Lexington; Stuart Urbach, Louisville; and Karl J. Winter, Louisville.

Tuesday, June 12
Everett Baker, Louisville; Guinn Cost, Hopkinsville; Warren Diessner, Middlesboro; Jessie Funk, Bowling Green; J. Duffy Hancock, Louisville; John E. Haynes, Dawson Springs; Thomas Hobbs, Lexington; Coleman Johnston, Lexington; Arthur L. Juers, Louisville; Maurice Kaufman, Lexington; Robert Lich, Jr., Louisville; Charles F. Long, Elizabethtown; Millard C. Loy, Columbia; Maurice Nataro, Louisville; James Davis, Louisville; Elliott Podoll, Louisville; Edward I. Rustin, Pikeville; Joseph Schicnel, Burkesville; William Lee Tyler, Owensboro; Sam D. Weakley, Jr., Louisville; and Roy G. Wilson, Campbellsville.

Tuesday afternoon, June 12
J. Andrew Bowen, Louisville; A. B. Carter, Fleming; Ballard Combs, Lexington; Armond T. Gordon, Louisville; J. A. Hoffmeister, Middlesboro; M. M. Lawrence, Jamestown; Walter L. O'Nan, Henderson; Robert P. Osburn, Louisville; Edward Ray, Lexington; E. Alden Terry, Louisville; and Auburn Wood.

Wednesday, June 13
Winston N. Bloch, Louisville; William McDaniel Ewing, Louisville; Robert M. James, Louisville; John M. Keaney, Louisville; John Lyford, Louisville; Condict Moore, Louisville; Mack Roberts, Monticello; George O. Roth, Louisville; and Otto H. Salsbery, Erlanger.

Wednesday afternoon and Thursday morning, June 13, 14
Champ Ligon, Lexington and Daniel N. Pickar, Louisville.

AMA Printing Plant Closed

The June 30 issue of the Journal of the American Medical Association was the last one to come off the presses in the AMA's Chicago printing plant. The Journal is now being printed by the McCall Corporation in Dayton, Ohio.

Several reasons were responsible for the move. Some were: not enough room at the headquarters building and old, out-of-date presses. The AMA print shop has been in operation 70 years.

The eighth Medical Editors' Meeting sponsored by the World Medical Association, will be held in Havana, Cuba, October 9-15. For more information write The World Medical Association, 10 Columbus Circle, New York 19, N. Y.

UL Med School Due $500,000; Sets Up Scholarship Plan

The University of Louisville School of Medicine will receive $500,000 a year—$200,000 more than it now gets—from the State under a contract authorized May 21 in Frankfort.

Under the terms of the contract the U of L Medical School agreed to refund the tuition of the school's medical graduates who practice in any one of the 10 critical counties. Also, the Medical Research Commission, which was formed in 1948 and which granted the school $300,000 a year, was abolished.

The new tuition-refund program is open to *all* alumnae of the medical school, if they agree to practice in one of the following counties: Breathitt, Cumberland, Elliott, Knott, Knox, Leslie, Magoffin, Martin, Powell and Rockcastle. The beneficiary will receive 50 per cent of his tuition at the end of the first year of practice—30 per cent at the end of the second and 20 per cent at the end of the third.

The $500,000 was appropriated by the 1956 General Assembly.

46 Hospitals Get Ford Grants Amounting to $1,061,750

Forty-six Kentucky hospitals have received a total of $1,061,750 from payments in the Ford Foundation's $200 million program aimed to help hospitals improve and expand their services to local communities. Approximately 3,500 hospitals throughout the US, Alaska, Hawaii and Puerto Rico are participating in the program.

The hospitals and individual payment totals were as follows:

Ashland:	Our Lady of Bellafonte Hospital	$ 17,700
Bardstown:	Flaget Memorial Hospital	7,450
Berea:	Berea College Hospital	9,900
Beverly:	Red Bird Evangelical Hospital	5,000
Corbin:	Southeastern Kentucky Baptist Hospital	11,350
Covington:	The William Booth Memorial Hospital	40,100
Cynthiana:	Harrison Memorial Hospital	9,000
Danville:	Ephraim McDowell Memorial Hospital, Inc.	19,750
Dayton:	Speers Memorial Hospital	22,750
Frankfort:	King's Daughters' Hospital	24,000
Hazard:	Mount Mary Hospital	29,950
Henderson:	Methodist Hospital in Henderson	19,150
Hyden:	Hyden Hospital and Health Center	5,000
Jenkins:	Sharon Heights Hosptial	9,150
Lexington:	Central Baptist Hospital, Inc.	16,450
	Cardinal Hill Convalescent Hospital	10,550
	Good Samaritan Hospital	84,450
	Our Lady of the Oaks Hospital	9,950
	St. Joseph Hospital	70,950
	Shriners Hospitals for Crippled Children	6,000
Liberty:	Casey County War Memorial Hospital	5,000
London:	Marymount Hospital	$ 6,850
Louisville:	Children's Hospital	31,900
	Kentucky Baptist Hospital, Inc.	96,500
	St. Joseph Infirmary	108,500
	SS. Mary and Elizabeth Hospital	47,050
	The Jewish Hospital	24,750
	Kosair Crippled Children Hospital	24,100
	John N. Norton Memorial Infirmary	63,850
	Red Cross Hospital Association	15,350
Lynch:	Notre Dame Hospital	9,950
Madisonville:	Hopkins County Hospital	27,200
Marion:	Crittenden County Hospital, Inc.	6,300
Martin:	Our Lady of the Way Hospital	6,850
Maysville:	Hayswood Hospital	18,300
Morganfield:	Our Lady of Mercy Hospital	5,500
Mt. Sterling:	Mary Chiles Hospital	8,650
Owensboro:	Our Lady of Mercy Hospital	16,150
Paducah:	Western Baptist Hospital, Inc.	16,600
Pikeville:	The Methodist Hospital	34,750
Pine Mountain:	Pine Mountain Hospital	5,000
Pineville:	Pineville Community Hospital	26,900
Princeton:	Caldwell County War Memorial Hospital	6,350
Shelbyville:	King's Daughters Hospital	9,850
Versailles:	Woodford County Memorial Hospital	5,950
Winchester:	The Edward O. Guerrant Memorial Hospital	5,000

Navy Will Need 380 Doctors Dr. McCarty Announces

Physicians just completing their internships and wishing to work off their military obligations before entering practice may apply now for a commission in the Navy, according to A. Clayton McCarty, M.D., Louisville, chairman of the KSMA Advisory Committee to Selective Service.

The Navy will need 380 physicians in October, November, and December. Dr. McCarty said it was understood that the Army and Air Force have their 1956 quota.

Physicians interested in having more information on the subject should either contact their Selective Service Board or write Frank B. Berry, M.D., Assistant Secretary of Defense, Washington 25, D. C.

MDs Plan Credit Bureau

A business bureau for collecting unpaid doctor bills and determining patients ability to pay is being planned by the Jefferson County Medical Society, according to published reports.

Most Louisville physicians now use the services of private collection and credit agencies. It is believed that the new medical bureau, which has been under study for a year, will be better able to handle these doctor-patient relations.



Representatives of the Rural Kentucky Medical Scholarship Fund and the 13 medical students who have been granted 1956 loans pose with Governor Chandler (center) at the May 31 meeting in Frankfort. The group met with Governor Chandler to thank him for a $50,000 appropriation which the General Assembly made to the Fund.

Dwight Murray Inaugurated as President of the AMA

Dwight H. Murray, M.D., general practitioner from Napa, California, was inaugurated as president of the American Medical Association at the Chicago Civic Opera House June 13. Dr. Murray succeeds Elmer Hess, Md., Erie, Pennsylvania.



Dr. Murray

Dr. Murray, in his inaugural speech, told the physicians, "we must humanize and personalize the practice of modern medicine." His talk, directed to the patient as well as the physician, asked the doctor to be "friendly, patient, and sympathetic." To the patient he said "have faith in the ability of your physician."

The 68-year-old Dr. Murray was born in Indiana. He received his MD from the Indiana Medical School and did post-graduate work at the University of Pennsylvania and the US Naval Medical School. Following his discharge from the Navy in 1922, he located in Napa.

The 'family style doctor'—as Dr. Murray describes himself—was elected chairman of the AMA's Board of Trustees in June 1951. He was also chairman of the Board's Committee on Legislation from January 1950 to December 1951.

Dr. Gernert Given KTA Plaque

E. Rudolf Gernert, M.D., Louisville, retiring president of the Kentucky Tuberculosis Association, was recently presented a plaque in recognition of his five years as president of the organization. Dr. Gernert is a 1921 graduate of the Medical Department of the University of Louisville.

Dr. Lawson Named President at Seventh District Meet

Fifty physicians and their wives attended the May 31 meeting of the Seventh Councilor District at the Frankfort Country Club, according to Branham B. Baughman, M.D., Frankfort, Seventh District councilor.

Reuben N. Lawson, M.D., Lawrenceburg, was elected president of the district. Hugh Williams, M.D., Carrolton was named vice-president and Donald Chatham, M.D., Shelbyville, secretary.

Gant Gaither, M.D., Hopkinsville, KSMA president, was the dinner speaker. His talk was entitled "In This Day of Printer's Ink." Scientific papers were presented by H. Burl Mack, M.D., Pewee Valley and Dr. Williams.

Franklin County was the host society. William S. Snyder, M.D., Frankfort, is president.

227 Attend McDowell Opening

Two hundred twenty seven persons registered at the 1956 formal opening of the McDowell House in Danville on May 27. The house, a shrine to Ephraim McDowell, M.D., is owned by the Kentucky State Medical Association.

Five KSMA Members Speak at Women's Club Meeting

"The Doctor's Role in Our Free Way of Life" was the title of the panel discussion presented by five KSMA members at the Kentucky Federation of Women's Clubs meeting in Louisville June 5.

Clyde C. Sparks, M.D., Ashland, immediate past-president of the Kentucky State Medical Association, was moderator of the panel. Panelists were: Vinson Pierce, M.D., Covington, AMA delegate; Garnett Sweeney, M.D., Liberty, member of the Committee on Medical Education; J. Duffy Hancock, M.D., Louisville, past president of the KSMA and W. Clark Bailey, M.D., Harlan, AMA delegate.

The panelists, who were selected by the KSMA Committee on Public Information and Service at the request of Mrs. S. H. Flowers, Middlesboro, Federation's retiring president, spoke at a dinner honoring federation district governors.

Medical Dept. Has New Head

Beverly Todd Towery, M.D., became the new chairman of the department of medicine at the University of Louisville School of Medicine July 1. He succeeds J. Murray Kinsman, M.D.



Dr. Towery

A graduate of the Vanderbilt School of Medicine, Dr. Towery has been associate professor of medicine there since 1953. (A biographical sketch of Dr. Towery appeared in the March Journal, page 271.)

U of L Honors Dr. Flexner

Dr. Abraham Flexner, who in 1908-1909 conducted a survey of the nation's medical schools, was awarded an honorary degree of doctor of science from the University of Louisville at its commencement exercises.

The 89-year-old Louisville-born scholar recently was awarded one of medicine's highest honors, the Frank Lahey Memorial Award for leadership in medicine. Dr. Flexner is not a doctor of medicine.

Dr. Bowers Heads Flying MDs

M. A. Bowers, Jr., M.D., Louisville, has been named president of the newly organized Kentucky Chapter of Flying Physicians. Other officers are: Luther Fuller, M.D., Louisville, vice-president and Homer Martin, M.D., Louisville, secretary-treasurer. The organization is composed of physicians who fly planes.

College Honors Dr. Pierce

W. Vinson Pierce, M.D., Covington, KSMA delegate to the American Medical Association, received an honorary degree in science from Georgetown College at its commencement exercises May 25. A graduate of the college Dr. Pierce received his medical degree from the University of Louisville School of Medicine.



G. Y. Graves, M.D., Bowling Green, (center) was installed as president of the Conference of Presidents and Other Officers of State Medical Associations at their meeting in Chicago, June 10. Congratulating him are: Charles Farrell, M.D., Pawtucket, Rhode Island, (right) out-going president and James Waggoner, executive secretary of the Indiana State Medical Society.

Foreign MD Evaluation Program Approved by AMA Trustees

The AMA Board of Trustees recently approved the program for evaluating foreign medical school graduates, and also the planning for the administration of a program as proposed by a Cooperating Committee on Graduates of Foreign Medical Schools.

The program is designed to clear up two main points which confront every foreign medical graduate who desires to come to the United States in any position that involves medical care of the American public. The points are: 1. The medical credentials of a foreign-trained physician must clearly indicate that he was graduated from a bonafide medical school, and 2. A foreign medical graduate must demonstrate by examination that he has medical knowledge equivalent to that demanded of graduates of schools in the United States.

Murray Kinsman, M.D., dean of the University of Louisville School of Medicine, was named a member of the Board of Trustees of the Cooperating Committee on GFMS.

MD Declines New York Offer

William K. Keller, M.D., professor of psychiatry at the University of Louisville School of Medicine and head of the psychiatry department at General Hospital recently turned down an offer to be mental-health director for the city of New York. Dr. Keller is a native of Louisville and a graduate of the University of Louisville Medical School.

New KSMA Members

The following physicians have been added to the KSMA membership roster:

G. Gordon Gussler, M.D., Ashland
J. L. Harris, M.D., Evarts
Maurice E. Kamp, M.D., Louisville
John T. Rawlings, M.D., Sharpsburg
E. T. Thorsness, M.D., Pikeville

OB-GYN Group Elects Officers

Hugh P. Adkins, M.D., is the new president of the Louisville OB-GYN Society. Other officers elected at the May 28 meeting were: Oscar Hayes, M.D., vice-president; and Douglas Haynes, M.D., secretary-treasurer.

Iowa MD Gets DSC Award

Walter L. Bierring, M.D., Des Moines, Iowa, 1934-35 president of the AMA, was awarded the Association's 1956 Distinguished Service Award at the Annual Meeting in Chicago.

The 88-year-old physician was honored for his achievements in public health and for 40 years of service in medical examining board work.

Pediatricians Elect Officers

Joseph J. Glaboff, M.D., was installed as president of the Louisville Pediatric Society May 28. Other officers elected were: Selby Love, M.D., president-elect; and Fred Pipkin, M.D., secretary.

News Items

William A. Rye, M.D., a '54 graduate of the University of Louisville School of Medicine has begun a general practice in Flemingsburg. He took his hospital training at St. Mary's Hospital in West Palm Beach, Florida.

Stonley Price, M.D., has started a practice in Louisville. A '54 graduate of the University of Louisville School of Medicine, he interned at General Hospital. Dr. Price recently completed some extra hospital training at GH.

Horold Beon, M.D., a '45 graduate of the George Washington University School of Medicine, has joined the staff of the United Mine Workers Hospital at South Williamson. Dr. Bean interned at the George Washington University Hospital.

Dorothy B. Worcester, M.D., has resigned as head of the baby clinic at the Kenton County Health Department. Dr. Worcester, a graduate of Northwestern University College of Medicine, had held the office for 17 years.

Helen Hallock, M.D., a practitioner in Stanford for about four and one-half years, recently announced her temporary retirement. Dr. Hallock was graduated from the University of Louisville School of Medicine in 1947.

Williom Beosley, M.D., a 1949 graduate of the University of Tennessee School of Medicine recently located in Hyden. Dr. Beasley took his hospital training at the Charity Hospital in New Orleans and the Methodist Hospital in Memphis. He served in the Army.

A country doctor in northern Ontorio left his ancient Model T Ford in front of the village drugstore and on his return found several of the youths who customarily loitered there making merry at the old car's expense. As he climbed into the well-worn driver's seat, the doctor inspected the group carefully then leaned out and said: "The car's all right, boys—it's paid for." "You"—and the doctor looked deliberately from one boy to another—"are not."

A RESEARCH MILESTONE

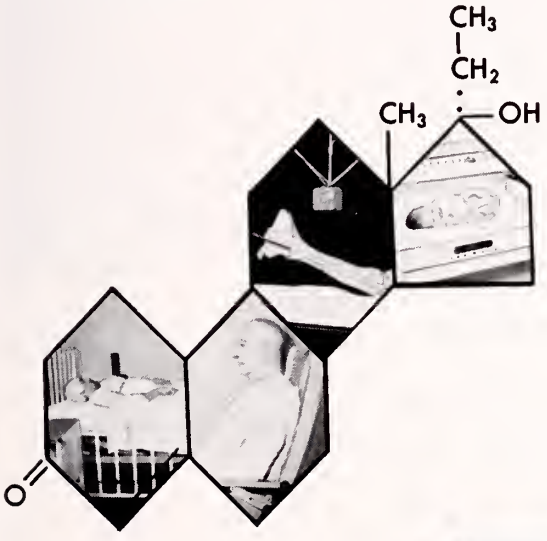
Nilevar*

(BRAND OF NORETHANDROLONE)

Searle's New and Practical Steroid Specifically for Protein Anabolism—

It has long been recognized that a substance which would promote protein anabolism would be of inestimable value in therapy. The androgens have this property, but unfortunately they also exert actions on secondary sex characteristics. These effects are commonly undesirable in therapeutic programs.

THE FIRST STEROID WITH ANABOLIC SPECIFICITY—Nilevar, the newest Searle Research development, therefore, meets a long desired clinical need because Nilevar presents the first steroid primarily anabolic for protein synthesis. Moreover, Nilevar is without prominent androgenic effects (only about one-sixteenth of that exerted by the androgens).



OBJECTIVE AND SUBJECTIVE RESPONSE — Orally effective, Nilevar therapy is characterized by retention of nitrogen, potassium, phosphorus and other electrolytes in ratios indicative of protein anabolism. Moreover, subjectively the patient observes an increase in appetite and sense of well-being.

WELL TOLERATED—Nilevar has an extremely low toxicity. Laboratory animals fail to show toxic effects after six months of continuous administration of high dosages. Nilevar should not be administered to patients with prostatic carcinoma. Nausea or edema may be encountered infrequently. Slight androgenicity may be evidenced on high dosage or in particularly responsive individuals.

MAJOR INDICATIONS—Preparation for and recovery from surgery; supportive treatment of serious illnesses (pneumonia, poliomyelitis, carcinomatosis, tuberculosis); recovery from severe trauma and burns; decubitus ulcers; care of premature infants.

DOSAGE—The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the average daily dose is 1 to 1.5 mg. per kilogram of body weight; individual dosages depend on need and response to therapy.

SUPPLY—Nilevar is available in uncoated, unscored tablets of 10 mg. G. D. Searle & Co., Research in the Service of Medicine.

*Trademark of G. D. Searle & Co.

SEARLE

In Memoriam

THOMAS G. VICARS, M. D.
Pineville
1873-1956

Dr. Vicars died, at the Pineville Community Hospital March 24, after an illness of several months. He was 83.

Dr. Vicars, after graduation from the University of Louisville School of Medicine in 1905, began his practice in Grays. In 1919 he went to Pineville.

L. WALLACE FRANK, M. D.
Louisville
1889-1956

Dr. Frank, one of the first surgeons in Kentucky to perform operations for pulmonary tuberculosis, died February 10 in St. Joseph Infirmary, Louisville. He had been hospitalized since January 1 for complications from a lung and heart ailment.

Dr. Frank helped form the first cancer clinic in Kentucky at Norton Memorial Infirmary in the 1930's. He wrote many papers on cancer treatment.

A 1914 graduate of the Medical Department of the University of Pennsylvania, Dr. Frank was on the staff of Norton Memorial Infirmary and St. Joseph Infirmary.

GEORGE MARION WELLS, M.D.
Bowling Green
1887-1956

Dr. Wells, founder of the Warren County Health Department, died February 25 of a heart attack. He was 68.

A 1916 graduate of Loyola University Medical School, Dr. Wells began his practice in Lafayette, Indiana. He went to Bowling Green in 1931.

During World War II he was regimental surgeon of the 149th Infantry. He was retired from the Army in 1945 as a lieutenant colonel.

L. SCOTT HAYES, M.D.
Louisa
1882-1956

Dr. Hayes died April 22 at the Louisa General Hospital, which he founded. He was 73.

A 1908 graduate of the Kentucky School of Medicine, Dr. Scott was once mayor of Louisa. He was a member emeritus of the KSMA.

LEONIDUS HUGHES, M.D.
Faubush
1877 - 1956

Dr. Hughes died at his home May 11 on his 80th birthday.

An 1899 graduate of the Barnes Medical School in St. Louis, Missouri, Dr. Hughes practiced medicine in Wayne, Russell, and Pulaski counties for 57 years.

Dr. Hughes was an emeritus member of the Kentucky State Medical Association.



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Member of the American Hospital Association and National Association of Private Psychiatric Hospitals

Four modern buildings, separate for men and women Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy, Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD, Hospital Administrator

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M.D., Neuropsychiatrist Medical Director

T. J. SMITH, M.D., Associate



Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

C I B A
Summit, N. J.

2/2228M

ROY ROBINSON, M.D.
Madisonville
1884-1956

Dr. Robinson, a physician in Madisonville for 50 years, died of a heart attack April 1. He was 72.

Dr. Robinson, a 1906 graduate of the Louisville Medical College, was on the staff of the Hopkins County Hospital. He was a member of the Kentucky State Medical Association and the American Medical Association.

T. A. E. EVANS, M.D.
Morehead
1874-1956

Dr. Evans died at his home in Morehead March 26. He was 82.

A 1907 graduate of the University of Louisville Medical Department, Dr. Evans was head of the Rowan County Health Department for 20 years. He served as judge of Rowan County for four years.

THOMAS CROW, M.D.
Manitou
1872 - 1956

Dr. Crow died in a rest home at Madisonville May 18. He was 94.

An 1896 graduate of the Hospital College of Medicine, Dr. Crow practiced in Manitou for 50 years. He retired 10 years ago.

RANDELL M. MULLINS, M.D.
Wingo
1928-1956

Dr. Mullins' body was recovered from the Rouge River in Detroit, Michigan, February 21. He had been missing since February 4 when he left the Henry Ford Hospital, where he was a resident physician, to visit a patient.

A native of Wingo, Dr. Mullins was a graduate of the University of Louisville School of Medicine. He joined the Henry Ford Hospital staff July 5, 1955.

ANCIL ADAMS RICHARDSON, M.D.
Williamsburg
1880-1956

Dr. Richardson, 75, died of a heart attack March 14. He had practiced medicine in Williamsburg since 1912.

Dr. Richardson was graduated from the Hospital College of Medicine in 1904. He began his medical practice in the mining areas of Catula and Westbourne, Tennessee.

A member of the Board of Trustees of the Cumberland College, Dr. Richardson was a deacon in the First Baptist Church. He was a member of the Williamsburg Rotary Club.

On his 73d birthday the people of Williamsburg paid tribute to his work by celebrating "Dr. A. A. Richardson Day."

JOSEPH WILLIAM PRYOR, M.D.
Lexington
1856-1956

Dr. Pryor, the first vice president of the KSMA, died at his home in March. He would have been 100 years old April 3.

Dr. Pryor, a former member of the Lexington-Fayette County Board of Health and past president of the Fayette County Medical Society, was a graduate of the University of Missouri School of Medicine.

In 1890 after a medical practice in Missouri, Dr. Pryor began teaching at the University of Kentucky. He taught anatomy and physiology until 1928 when he retired.

He was a member of the AMA, SMA and the KSMA. Dr. Pryor belonged to the First Presbyterian Church.

ELBERT McKENNEY, M.D.
Louisville
1870-1956

Dr. McKenney, 85, died at the Kentucky Baptist Hospital March 15.

An 1898 graduate of the Kentucky School of Medicine, Dr. McKenney practiced in Louisville for 53 years. Before coming to Louisville he practiced at Caneyville for four years.

Dr. McKenney taught at the University of Louisville for several years and served as physician for the Presbyterian Orphans Home. He was a member of the KSMA, AMA and SMA.

MARTIN PALMER, M.D.
Hazard
1901-1956

Dr. Palmer, a founder of the Hazard Clinic, died of a heart attack while making his rounds at Mount Mary Hospital April 17.

A native of Alabama, Dr. Palmer was graduated from the University of Louisville School of Medicine.

He went to Perry County in 1931 and began a practice at Harvey. From 1944 to 1947 he specialized in internal medicine at the Louisville General Hospital. He returned to Hazard in 1947.

Dr. Palmer, a member of the KSMA, AMA, and SMA, was past president of the Perry County Medical Society.

DARWIN SMITH, M.D.
Corbin
1910 - 1956

Dr. Smith died April 29 at the Southeastern Kentucky Baptist Hospital of a heart attack.

After graduation in 1938 from the Medical College of Virginia, Dr. Smith began his practice in Stone. From 1942 to 1945 he served in the army. Following his discharge he located in Cumberland. In 1952 he went to Corbin.

He was a member of the Kentucky State Medical Association and the American Medical Association.

The American Academy of Obstetrics and Gynecology was renamed the American College of Obstetricians and Gynecologists, May 11 according to Ralph E. Campbell, M.D., president of the college.

CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of
mental and nervous disorders, and
addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director



'Thorazine' relieved this patient's anxiety, tension and fear and made it possible for him to return to work.

'THORAZINE' CASE REPORT

patient: Anxiety, tension, and a fear of going out alone made it impossible for this 36-year-old man to work. After other treatments had failed he was given 'Thorazine'.

response: "On 'Thorazine' medication, 100 mg. orally, daily, his anxiety and apprehension disappeared rapidly. The patient was able to go out alone and to work once again. His mood was actually gay and his co-workers were surprised at this change. He was now free from care whereas before he had been distressed by the slightest difficulty."

This case report is from the files of a general practitioner.

THORAZINE*

Available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

Smith, Kline & French Laboratories, Philadelphia

'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

*T.M. Reg. U.S. Pat. Off: for chlorpromazine, S.K.F.

COUNTY SOCIETY REPORTS

CALLOWAY

The Calloway County Medical Society met in the conference room of the Murray Hospital, April 3. Charles Clark, M. D., president, presided.

Physicians present at the meeting were: A. D. Butterworth, Charles Clark, Robert Hahs, Hugh Houston, C. H. Jones, C. C. Lowry, O. K. Mason, R. M. Mason, John Quertermous, Harry Whayne, and Vernon Pettit.

Dr. Clark read a report from the Blue Shield Plan. The report showed that Kentucky doctors were paid $2,469,522 last year—an increase of $661,054 over the previous year.

Dr. Quertermous made a motion seconded by Dr. Lowry that Dr. Houston, Dr. Hart and Dr. Butterworth, as a committee, go before the Board at the Calloway County Health Center and again request that the motion voted on at the September 6, 1955 meeting be carried out. The motion was: "The Calloway County Health Office allocate to the doctors 90 per cent of the Salk Polio Vaccine which will be issued in the near future for distribution to children from one to nine years of age, and that 10 per cent be left at the Calloway County Health office to be issued for indigent patients. The county judge will be asked to decide who the indigent patients will be."

Hugh Houston, M. D., Secretary

PIKE

The regular monthly meeting of the Pike County Medical Society was held at Langley's Cafe on April 17. F. H. Hodges, M. D. president, presided.

W. C. Hambley, M. D., made a motion that the society meet at the Green Meadow Country Club in May, September and December. Motion was seconded by W. F. Clarke, M. D., and carried.

E. I. Rustin, M. D., county health officer, presented the program of the Pike County Health Department in the tuberculosis drive and R. W. Allen, M. D., made a motion that the Pike County Medical Society endorse this program 100 per cent. The motion carried.

H. Halbert Leet, M. D., Lexington, conducted the scientific program for the evening. The program, a round table discussion of psychiatric problems, featured the following panelists: Dr. Leet, F. H. Hodges, M. D.; A. G. Osborne, M. D. and W. F. Clarke, M. D.

Ballard Cassady, M. D., Secretary-Treasurer

SHELBY - OLDHAM

The Shelby-Oldham County Medical Society held its April dinner meeting at the Old Stone Inn in Simpsonville. Twenty six members were present.

A committee was appointed to arrange the annual picnic in June.

The members were urged to attend the district meeting in Frankfort on May 30.

The scientific program was presented by Marvin

the most complete optical service in kentucky

Southern Optical COMPANY

HOME OWNED SINCE 1897

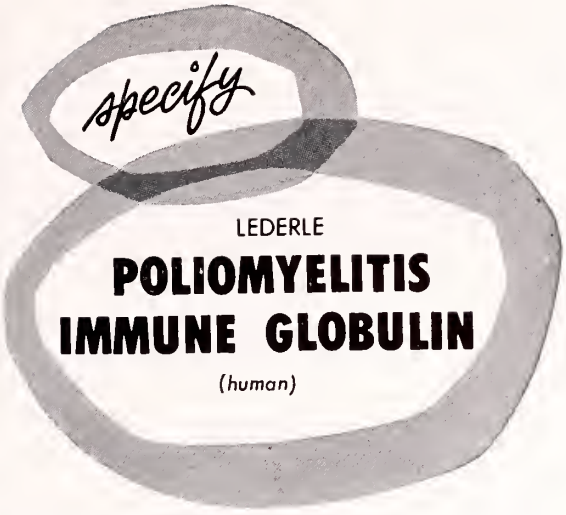
CONTACT LENSES
(Fluidless Lacrilens—Corneal)

ARTIFICIAL EYES
(Custom Plastic—Glass)

4th and Chestnut
334 W. Broadway
LOUISVILLE

GUILD OPTICIANS





Lucas, M.D., Louisville. He spoke on proctology.

The next regular meeting of the society will be held on September 27.

C. C. Risk, D.D.S., Secretary

McCRACKEN

The McCracken County Medical Society met March 28. Vernon Pettit, M.D., presided.

Rex Holland, M.D., discussed the Heart Clinic.

The motion was made and seconded that the motion concerning the Heart Clinic which was passed February 22 be stricken from the record. This passed unanimously.

Walter Johnson, M.D., was the scientific speaker for the evening. He discussed "Management of the Menopause."

The society agreed to have a cocktail party at the April meeting.

C. P. Orr, M.D., Secretary

The Disability Freeze

(Continued from Page 616)

a medical advisory committee were closely followed. This committee, composed of well qualified representatives of the medical and related non-medical professions, gives advice and guidance to the Social Security Administration on the medical aspects of the "disability freeze" program.

If you have received this medical form to fill out for any of your patients, you are probably aware that the law makes the disabled worker responsible for seeing that medical evidence is submitted for him and for paying any costs involved. The law does not permit the Government to pay any costs in connection with securing the medical evidence needed for a determination of disability. You may also know that to insure the confidentiality of the medical evidence, the medical report form is not to be returned to the patient, but is to be mailed by the physician direct to the local social security office. This office, incidentally, is ready to furnish additional information to the physician concerning the medical report form and the operation of the disability freeze.

Determining Disability

Determinations as to disability based on the evidence submitted are made under an agreement with the Federal Government, by professional members of an agency of the State in which the applicant resides. In most States, this is the vocational rehabilitation agency. Since referral of disabled individuals for any

EVERY WOMAN

WHO SUFFERS

IN THE

MENOPAUSE

DESERVES

"PREMARIN"®

widely used

natural, oral

estrogen

AYERST LABORATORIES

New York, N. Y. • Montreal, Canada

5645

rehabilitative services which might return them to gainful work is an important aspect of the program, each person applying for the social security disability freeze is told about the availability of vocational rehabilitation services.

On the professional team in the State agency at least one member is a doctor of medicine. The team reviews and evaluates all medical evidence assembled in the applicant's file, as well as such non-medical factors as age, education and occupational experience. Certain medical guides and standards, worked out with the advice of the medical advisory committee are used in the consideration of the medical evidence. But, although these guides and standards can be applied in most cases, they are not rigid and arbitrary. The final determination in each case is based on all the available facts on the individual's impairment and vocational history, and, there is consultation among physicians in any borderline situation.

Guides to Filling Out the Medical Report Form

No matter how good the standards, nor how considered the judgment of the reviewing team, the determination reached can be no sounder than the evidence upon which it is based. To make sure that he is providing sufficient medical evidence for a prompt and fair determination, the doctor will want to consider the following guides in filling out medical report forms for those of his patients who have applied for the social security disability freeze:

1. Include sufficient clinical detail to enable the reviewing team to make a sound determination as to the severity and extent of the patient's current condition;
2. Give enough of the clinical history to provide information as to when the disability began and when it became so severe as to keep the patient from working;
3. Describe the probable course of the condition from now on, so that a decision can be reached as to whether the impairment is likely to continue indefinitely, or end in death, or whether it is self-limiting or remediable in the foreseeable future.



For

HAY FEVER,

COLDS,
SINUSITIS

NTZ®

Nasal Spray

CONVENIENT NONBREAKABLE SQUEEZE BOTTLE

A physiologically balanced formulation of three well known and widely used compounds:

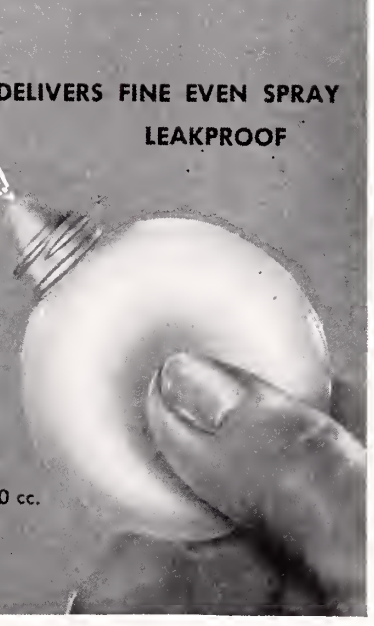
Neo-Synephrine® HCl, 0.5%
dependable decongestant

Thenfadil® HCl, 0.1%
powerful antihistaminic

Zephiran® Cl, 1:5000
wetting agent and antibacterial

DELIVERS FINE EVEN SPRAY
LEAKPROOF

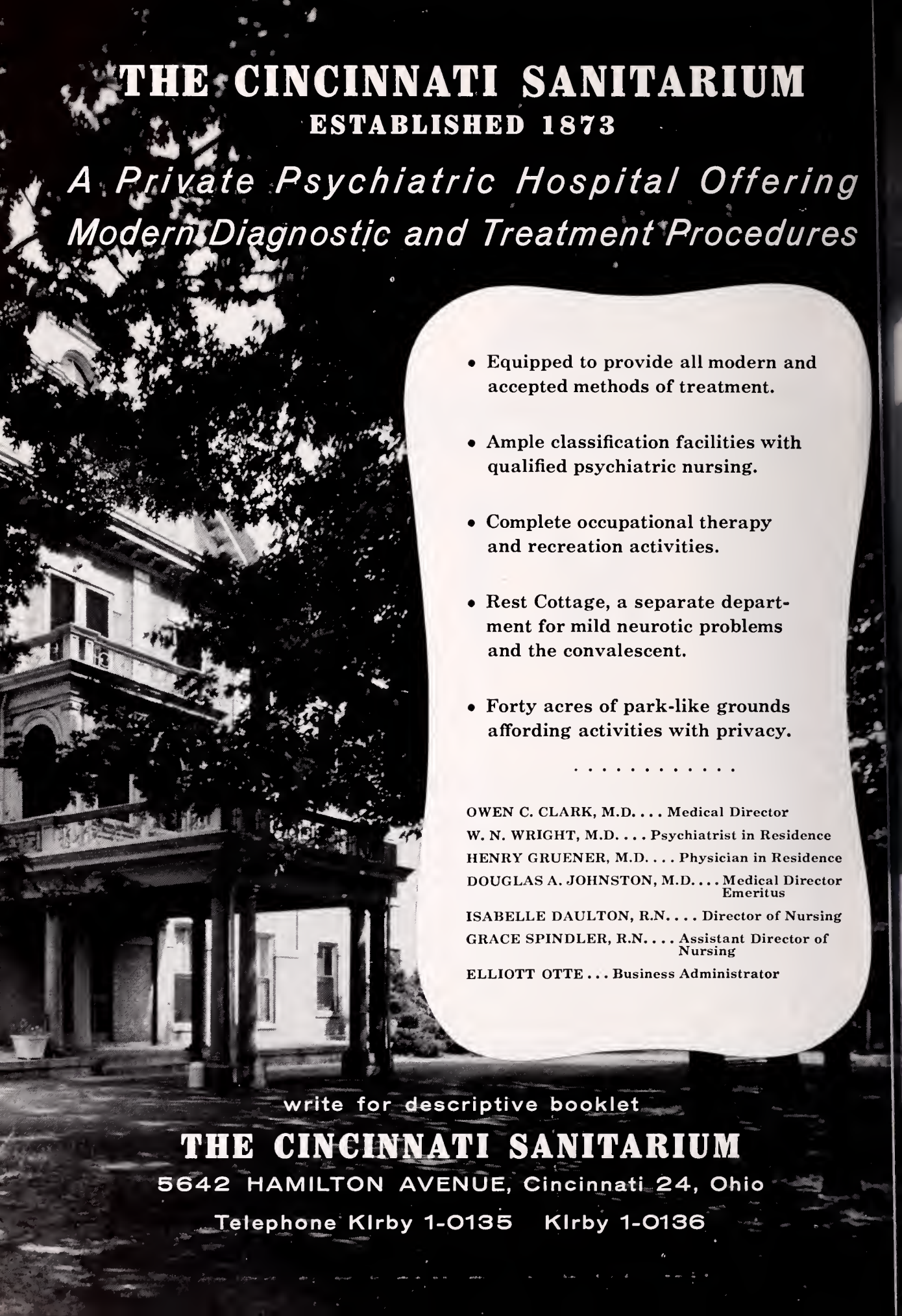
Rapidly Effective
No Antibiotic Sensitization



Supplied in spray bottle containing 20 cc.

Winthrop LABORATORIES • NEW YORK 18, N. Y.

NTZ, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U.S. Pat. Off.



THE CINCINNATI SANITARIUM

ESTABLISHED 1873

A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
- Ample classification facilities with qualified psychiatric nursing.
- Complete occupational therapy and recreation activities.
- Rest Cottage, a separate department for mild neurotic problems and the convalescent.
- Forty acres of park-like grounds affording activities with privacy.

. . . . . .

OWEN C. CLARK, M.D. . . . Medical Director
W. N. WRIGHT, M.D. . . . Psychiatrist in Residence
HENRY GRUENER, M.D. . . . Physician in Residence
DOUGLAS A. JOHNSTON, M.D. . . . Medical Director Emeritus
ISABELLE DAULTON, R.N. . . . Director of Nursing
GRACE SPINDLER, R.N. . . . Assistant Director of Nursing
ELLIOTT OTTE . . . Business Administrator

write for descriptive booklet

THE CINCINNATI SANITARIUM

5642 HAMILTON AVENUE, Cincinnati 24, Ohio

Telephone KIrby 1-0135 KIrby 1-0136



HydroCortone® -T.B.A.

(HYDROCORTISONE *TERTIARY*-BUTYLACETATE, MERCK)

produces superior results — greater symptomatic relief and longer-lasting remissions — in both rheumatoid arthritis and osteoarthritis.

SUPPLIED: SALINE SUSPENSION HYDROCORTONE-T.B.A.—25 MG./CC., VIALS OF 5 CC.

References: 1. Hollander, J. L., *Ann. New York Acad. Sc.* **61**:511, May 27, 1955.
2. Hollander, J. L., *et al. J.A.M.A.* **158**:476, June 11, 1955.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

"...in patients with moderately severe and severe cardiac failure, neohydrin is the oral diuretic of choice."*

*Moyer, J. H., and others:
J. Chronic Dis. 2:670, 1955.

03056

PATENTED ARCH SUPPORT CONSTRUCTION — WIDE STEEL SHANK IMBEDDED IN PLASTIC COMPOUND ★



- Insole extension ond wedge ot inner corner of heel where support is most needed.
- ★ The potented orch support construction is guoronteed not to breok down.
- Innersoles guaranteed not to crack or collopse.
- Foot-so-Port losts designed ond the shoe construction engineered with orthopedic odvice.
- Conductive Shoes for surgical ond operating room personnel. N.B.F.U. specifications.
- We ore also the monufocturer of the Gear-Action Shoe designed by noted orthopedic surgeon.
- We moke more shoes for polio, club feet ond disobled feet thon ony other shoe monufocturer.

Send for free booklet, "The Preservotion of the Function of the Foot Boloncing ond Synchronizing the Shoe with the Foot."

Write for detoils or contoct your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.
A Division of Musebeck Shoe Company

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

Available

Tax Returns
Bookkeeping
Delinquent Accounts
(No Commission)
Office Routines
Office Planning
Instructing Personnel
Fees
Partnerships
Hospitals
Clinics
Counselling - Investments
Insurance

ASSOCIATES:

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hubert G. Stiffler
Daniel L. Zeiser
Richard J. Conklin

PROFESSIONAL BUSINESS MANAGEMENT

FOR DOCTORS ONLY

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945
WOodburn 1-1010

141 West McMillan Street
Cincinnati 19, Ohio

I would like to talk with one of your representatives

Name .....

Address .....

..... Telephone .....

All Services Completely Confidential

WHAT IS THE DIFFERENCE BETWEEN A TRANQUILIZER AND A SEDATIVE?

Comparison of the effect of Raudixin (tranquilizer) and a barbiturate (sedative) on the cortical electroencephalogram



No drug.



After Raudixin. E. E. G. not altered.



After barbiturate. Typical "spindling" effect.

Because barbiturates and other sedatives depress the cerebral cortex, the sedation achieved is accompanied by a reduction in mental alertness.

Raudixin acts in the area of the midbrain and diencephalon, and does not depress the cerebral cortex. Consequently, the tranquilizing (ataractic) effect achieved is generally free of loss of alertness.

RAUDIXIN

Squibb Whole Root Rauwolfia Serpentina

DOSAGE: 100 mg. b.i.d. initially; may be adjusted within a range of 50 mg. to 500 mg. daily. Most patients can be adequately maintained on 100 mg. to 200 mg. per day.

SUPPLY: 50 mg. and 100 mg. tablets; bottles of 100, 1000 and 5000.

SQUIBB *Squibb Quality—the Priceless Ingredient*

'RAUDIXIN'® IS A SQUIBB TRADEMARK

for the acutely agitated...

QUIESCENCE AND EMOTIONAL DETACHMENT

NEW Potent Ataraxic

Sparine*

HYDROCHLORIDE

Promazine Hydrochloride

10-(γ-dimethylamino-*n*-propyl)-phenothiazine hydrochloride

INDICATIONS:

- The acute alcoholic[1,2]—delirium tremens, acute hallucinosis, tremulousness
- The acute psychotic[1]—acute excitation due to various psychoses
- The drug addict[1]—withdrawal syndrome: nausea, vomiting, muscle and bone pains, abdominal cramps, general malaise

FINDINGS:

"The drug ... is effective in ... maintaining these subjects in a quiescent detached state.... Complications such as jaundice, ... dermatitis, edema, lactation, basal ganglion disturbances, or depression were not observed during these studies."[1]

As with any new and potent agent, it is well to be fully informed on the precautions of use and the possibility of side-effects. Before prescribing SPARINE, the physician should consult the direction circular.

For intravenous, intramuscular, or oral administration.

Supplied: Tablets, 25, 50, and 100 mg., bottles of 50 and 500; 200 mg., bottles of 500. Injection, 50 mg. per cc., vials of 2 and 10 cc.

1. Fazekas, J.F., et al.: J.A.M.A. **161**:46 (May 5) 1956. 2. Mitchell, E.H.: J.A.M.A. **161**:44 (May 5) 1956.

*Trademark

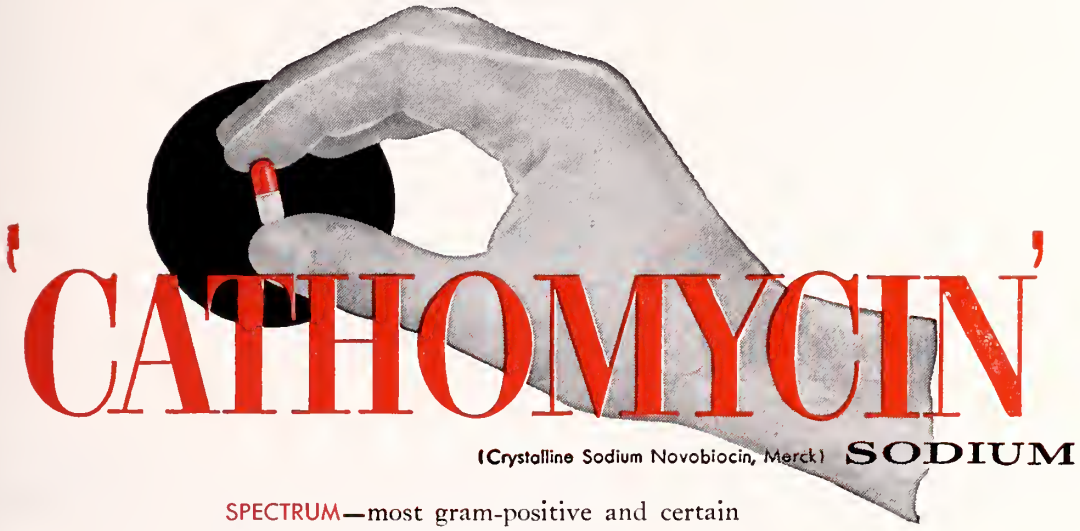
Wyeth®
Philadelphia 1, Pa.

An Exclusive Development of Wyeth Pharmacological Research

NOW AVAILABLE...

a unique new antibiotic of major importance

PROVED EFFECTIVE AGAINST SPECIFIC ORGANISMS
(staphylococci and proteus)
RESISTANT TO ALL OTHER ANTIMICROBIAL AGENTS



'CATHOMYCIN'

(Crystalline Sodium Novobiocin, Merck) **SODIUM**

SPECTRUM—most gram-positive and certain gram-negative pathogens.

ACTION—bactericidal in optimum concentration even to resistant strains.

TOXICITY—generally well tolerated. This is more fully discussed in the package insert.

ABSORPTION—oral administration produces high and easily-maintained blood levels.

INDICATIONS—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris;* including strains resistant to all other antibiotics.

DOSAGE—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

'CATHOMYCIN' *is a trademark of Merck & Co., Inc.*

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

POSITIONS OPEN

STATE TUBERCULOSIS HOSPITAL COMMISSION

The State Tuberculosis Hospital Commission is interested in employing physicians who have qualified for their Kentucky license. Assistant Medical Directorships and staff positions are available. Prior experience in diseases of the chest is not required.

Compensation for an Assistant Medical Director includes a salary of $8500 per year in addition to a furnished two-bedroom apartment, utilities, food as supplied and laundry.

Specific openings are available at the District One State Tuberculosis Hospital, Madisonville and the District Two State Tuberculosis Hospital, Louisville (Hazelwood). Each institution has a close working relationship with a nearby general hospital.

Those interested should apply to:

C. C. Howard, M.D. Chairman
State Tuberculosis Hospital
Commission
c/o Howard Clinic
Glasgow, Kentucky

—or—

Mr. Joe D. Miller
Executive Director
State Tuberculosis
Hospital Commission
New State Office Bldg.
Frankfort, Kentucky

OVER 3 MILLION FACTS

IN THE NEW EIGHTEENTH EDITION

DATA ON 219,677 PHYSICIANS

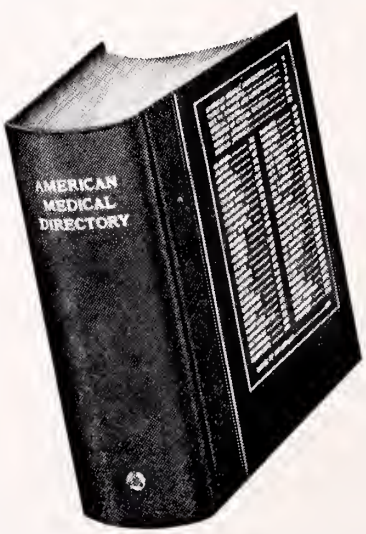
Physicians grouped alphabetically by cities and states, with year of birth; school, year grad.; state license; military service; whether diplomate of Natl. Board of Med. Examiners, or certified by one of examining boards in med. specialties; home, office addresses; member special society; medical school professorship.

LICENSING AND EXAMINING BOARDS, HEALTH OFFICERS

Shows State Board of Med. Examiners for each state; personnel of Natl. Board of Med. Examiners; educ. requirements of applicants, plan of Natl. Board examinations. Also Examining Boards in Med. Specialties; lists of Health Officers—state, district, county, city.

MEDICAL LAWS; JOURNALS; LIBRARIES

Medical Practice Act, Digest of Law and Board Rulings. Requirements for examination and reciprocity, grounds for refusing, revoking or suspending a license, penalties for violation of the Act. Also fees for licensure, dates of meetings, name and address of executive officer.



American Medical Association
535 N. Dearborn St., Chicago 10

369 medical libraries, with addresses, number volumes, names of librarians. 246 medical journals listed.

FACTS ON 7,482 HOSPITALS

Listing all recognized hospitals and sanatoriums of each state—name and address, year established, type of service; number of beds; how controlled; whether approved for general internship and residencies in specialties; director's name.

ALPHABETICAL INDEX OF PHYSICIANS

All physicians are alphabetically listed by name, with city location.

MEDICAL SCHOOLS

Existing and extinct, arranged chronologically under state. A general descriptive section shows all schools geographically, with history, location, name of dean.

MEDICAL SOCIETIES

Members of special societies grouped geographically, classified by related interests in seven groups. Names of nearly 150 societies shown.

18th Edition **AMERICAN MEDICAL DIRECTORY** Price $25.00

Pertinent Paragraphs

The Southeastern Surgical Congress recently announced its Annual Prize Scientific Paper Award for 1957. The author of the best unpublished paper on surgery or allied subjects will be awarded $100 and an expense paid trip to the Congress' next annual meeting in St. Petersburg, Florida. For more complete information write: A. H. Letton, M.D., Chairman, Scientific Paper Award Committee. The Southeastern Surgical Congress, 701 Hurt Building, Atlanta, 3, Georgia.

The Committee on Careers, National League for Nursing, recently announced the availability of material concerning graduate nurse study. "The demand for nurses with leadership training," said John Hayes, chairman of the committee, "can be an incentive to any nurse to set her sights high in planning her professional career." More information can be obtained at cost by writing to: Committee on Careers, National League for Nursing, 2 Park Avenue, New York 16, N. Y.

Sam T. Gibson, M.D., became national director of the Red Cross Blood Program and acting medical director of the American National Red Cross June 15. Dr. Gibson, associate director since November 1952, succeeds David N. W. Grant, M.D. Dr. Gibson was in Louisville at the 1953 annual meeting of the Louisville Red Cross Chapter.

The New York Medical College recently announced a Post-Graduate Course in Pediatric Allergy beginning November 7, 1956 and running through May 29, 1957. The 30 session course will be under the direction of Bret Ratner, M.D., professor of clinical pediatrics and associate professor of immunology. To apply for enrollment write: Office of the Dean, New York Medical College, Fifth Avenue at 106th Street, New York 29, N. Y.

The Seventh Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, November 14-22, 1957, according to F. J. Pinkerton, M.D., director general. Dr. Pinkerton urged interested physicians to make arrangements as soon as possible. For more complete information write to Dr. Pinkerton, Director-General of the Pan-Pacific Surgical Association, Room 230, Young Building, Honolulu, Hawaii.

The nation gained 3,800 physicians during 1955, according to a recent release from the American Medical Association. Seven thousand seven hundred thirty seven were licensed, but nearly 4,000 physicians died during the year, leaving 3,800. One hundred eight were licensed by examination in Kentucky last year and 90 who had previously practiced elsewhere were granted Kentucky licenses.

"Summer Serenade" a 13 program transcription series is now available to state and county medical societies for airing over local radio stations. The series prepared by the AMA's Bureau of Health Education features tips on summertime health topics interspersed with classical and semi-classical music. For more information contact the Bureau of Health Education, 535 N. Dearborn Street, Chicago 10, Illinois.

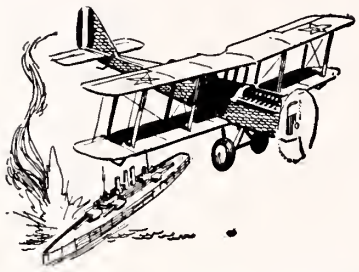
Relax the best way
... pause for Coke



continuous quality
is quality you trust

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

Mr. Daniels was willing to be bombed





ADMIRALS smiled when, in 1921, he claimed air power could sink battleships. And Mr. Josephus Daniels, the Navy secretary, said he was "prepared to stand bareheaded on the deck of a battleship and let General Mitchell take a crack at me with bombing airplane."

But in an actual test, the most heavily armored dreadnaught ever built sank in minutes under the sledge-hammer blows of the world's first 1-ton bombs—bombs built to Billy Mitchell's order.

Mitchell was used to disbelief. In World War I, Pershing called his idea for dropping infantry by parachute absurd. "Experts" laughed when he talked of putting cannon in planes, scoffed when he predicted air speeds way in excess of 200 miles.

In his early fight for a strong air force, Mitchell saw very dark days. Yet he never lost faith in the American people, nor they in him. For they recognized his clear foresight and great fighting heart as part of the real American spirit.

It is this courageous spirit that makes America strong—so strong, in fact, that our country's Savings Bonds are regarded as one of the finest investments in the world.

Why not take advantage of that strength? Use United States Savings Bonds to guard your future, and your country's future. Invest in them regularly—and hold onto them.

It's actually easy to save money—when you buy United States Series E Savings Bonds through the automatic Payroll Savings Plan where you work! You just sign an application at your pay office; after that your saving is done for you. And the Bonds you receive will pay you interest at the rate of 3% per year, compounded semiannually, for as long as 19 years and 8 months if you wish! Sign up today! Or, if you're self-employed, invest in Bonds regularly where you bank. There's no surer place to put your money, for United States Savings Bonds are as safe as America!

Safe as America—
U.S. Savings Bonds

PUBLIC SERVICE · ADVERTISING COUNCIL ·

The U.S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

5 1-2 x 8 in. 100 Screen

CORRECT CONSTIPATION... RESTORE HABIT TIME OF BOWEL MOVEMENT

PETROGALAR®

Aqueous Suspension of Mineral Oil, Plain

Bottles of 1 Pint



Wyeth®
Philadelphia 1, Pa.

WAYSIDE HOSPITAL

168 North Broadway
Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

APPROVED BY AMERICAN MEDICAL ASSOCIATION

STAFF

H. HALBERT LEET, M.D. — JOHN H. ROMPF, M.D.
CARL WIESEL, M.D. — IRVING A. GAIL, M.D.
EDWARD L. HOUCHIN, ADMINISTRATOR

Phone: 2-2050

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)

(The Pioneer Postgraduate Medical Institution in America)

UROLOGY

A combined full-time course in Urology, covering on ocodemic yeor (8 manths). It comprises instruction in phormacolagy; physialagy; embryalagy; biochemistry; bocteriology ond pothalogy; procticol work in surgicol anotomy ond urological aperotive procedures on the cadaver; regionol ond generol onesthesio (cadover); office gynecology; proctalagical diognosis; the use af the aphtholmoscope; physicol diagnasis; roentgenologicol interpretotion; electrocordiographic interpretation; dermotalogy ond syphilalagy; neurologic physicol medicine; cantinuaus instructian in cysto-endascapic diognosis ond operotive instrumental monipulotion; operotive surgicol clinics; demonstrotions in the aperative instrumentol monagement af bladdei tumors ond ather vesicol lesians os well os endoscapic prostotic resection.

PROCTOLOGY and GASTROENTEROLOGY

A combined course comprising attendonce ot clinics ond lectures; instruction in exominatian, diagnasis and treotment; pothology, rodiology, onotamy, aperotive proctology an the cadover, anesthesiology, witnessing of operotians, examinotian af patients preaperotively ond postoperotively in the wards and clinics; ottendonce at departmentol ond generol conferences.

For Information about these and other courses Address:

THE DEAN, 345 WEST 50th St., New York 19, N. Y.

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your eligible dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$23,800,000 PAID FOR BENEFITS SINCE ORGANIZATION

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

organomercurial diuretics "...permit ingestion of enough salt to make food palatable; without them, many patients would lose their appetites, a consequence of the salt-free diet which has occasionally been known to cause serious malnutrition."*

*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

03156

NEW CASTLE SANITARIUM

Telephone 3621
NEW CASTLE, KY.

For the care of
CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the American Hospitol Associotion
Member of the Americon Assn. of Nursing Homes
Licensed ond Approved by the Stote of Kentucky

SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE
PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS
24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES
New Selectemp Moduloted Steom Heot With Filtered Air For Maximum Comfort ond Sofety
Protected Throughout With Automotic Fire Detection ond Alorm System

IRA O. WALLACE, Administrotor

looked over often...

the patient with nonspecific rheumatism

NOW—thoroughgoing relief with

NEW SIGMAGEN TABLETS



combining

Prednisone	0.75 mg.	—best of the new
Acetylsalicylic acid . . .	325 mg.	—best of the old
Ascorbic acid	20 mg.	
Aluminum hydroxide . .	75 mg.	

antirheumatic • anti-inflammatory • analgesic • supportive

Combined effectiveness of the antirheumatic agents in SIGMAGEN permits maintenance of clinical relief at minimal dosages.

SIGMAGEN,* brand of corticoid-analgesic compound.
*T.M.

Schering

SG-J-51

OCULISTS' PRESCRIPTIONS EXCLUSIVELY

MUTH OPTICAL COMPANY

Prescription Opticians

665 S. 4th | Brown Hotel Building | Louisville 2

Clearview

On The Kratzville Road

EVANSVILLE, IND.

TELEPHONE 5-6181

A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.

SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery

ELECTROENCEPHALOGRAPH — CLINICAL LABORATORY—EKG AND BMR EQUIPMENT—STEREOSCOPIC X-RAY — HYDROTHERAPY.

ALBERT J. CREVELLO, M.D.
Diplomate, American Board of Psychiatry & Neurology, Inc.
MEDICAL DIRECTOR

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.

REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465
334 W. BROADWAY
LOUISVILLE, KENTUCKY

WAbash 6725

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**
( ) **Centralized Bookkeeping** (Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**

SECLUSION MATERNITY



FAIRMOUNT HOSPITAL

FOR UNMARRIED GIRLS

Est. 1909

Private sanitarium with certified obstetrician in charge. Folder fully describing services FREE on request. Early entrance advised.

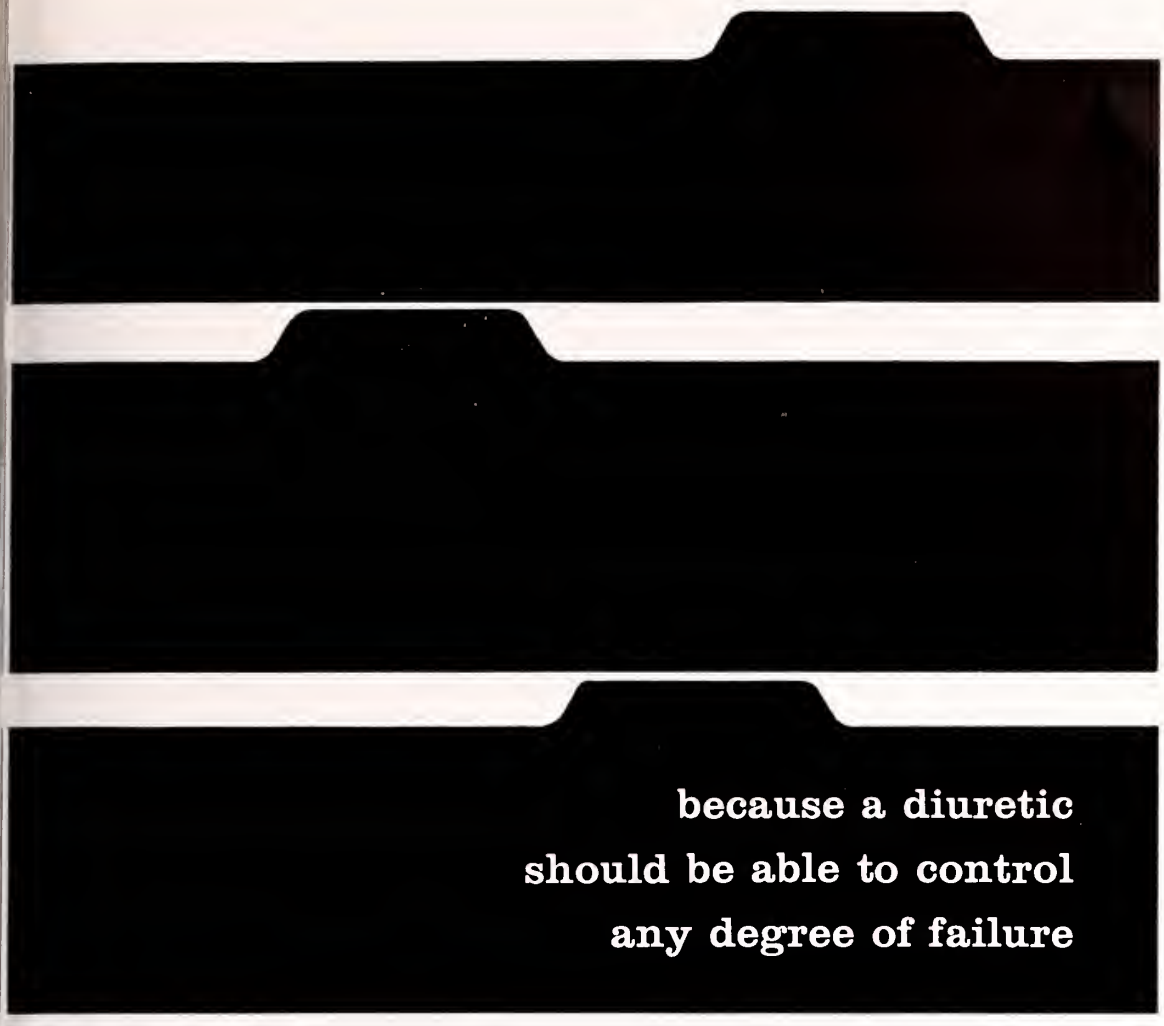
Rates reasonable. In certain cases work given to reduce expenses.

Write for Information

HELEN AMOS
4911 East 27th St.
Kansas City, Mo.
Phone: WA. 3-3577

PLEASE NOTICE

Advertising space in the Kentucky Medical Journal is worth just what you make it. When you buy from firms advertising in the Kentucky Medical Journal, you protect yourself against questionable products and you increase the value of this, your own Journal, to its advertisers. If a product is not advertised in the Kentucky Medical Journal, it may have been declined in order to protect you. Remember this, and use these pages as your buying guide.



PATIENTS IN FAILURE NEED AN ORGANOMERCURIAL

Certain diuretics are apt to mask the gradual onset of severe failure because they are effective only in the milder ambulatory cardiacs. The recurrent accumulation of fluid permitted by intermittent or arbitrarily limited dosage must eventually progress to more severe decompensation.

Because they can control *any* grade of failure, the organomercurials improve prognosis and prolong life.

TABLET

NEOHYDRIN®

BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure

MERCUHYDRIN® SODIUM

BRAND OF MERALLURIDE INJECTION

01356

LAKESIDE

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS—1955-56

Gant Gaither, 109½ East 7th Street, Hopkinsville ..... President
Richard R. Slucher, 2202 Seiger Villa, Louisville ..... President-elect
Clyde C. Sparks, M.D., Mayo Arcade Ashland ..... Immediate Past President
Everett Baker, 408 Brown Bldg., Louisville ..... Vice-President
N. Lewis Bosworth, M.D., 1701 Fincastle Rd., Lexington ..... Vice-President
Howell J. Davis, 330½ Allen, Owensboro ..... Vice-President
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Secretary-Editor Pro tem
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Treasurer
Charles A. Vance, 271 W. Short Street, Lexington ..... Speaker—House of Delegates
E. W. Jackson, 333 Broadway, Paducah ..... Vice Speaker—House of Delegates
J. Vernon Pace, 709-10 Citizen's Bank Bldg., Paducah ..... Chairman of the Council
Delmas M. Clardy, Hopkinsville ..... Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan	1956
Robertson Joplin, Brown Bldg., Louisville	1956
W. Vinson Pierce, 33 E. Seventh St., Covington	1957
Leon Higdon, 333 Broadway, Paducah, (Alternate)	1957

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Building, Paducah	1956
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1958
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Carlisle Morse, 3612 Lexington Road, Louisville	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1958
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1957
Ninth District	J. M. Stevenson, Brookville	1958
Tenth District	J. Farra Van Meter, 183 N. Upper Street, Lexington	1958
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1958
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Charles B. Stacy, Pineville	1957

BUYERS GUIDE

JOURNAL OF THE KENTUCKY STATE MEDICAL ASSOCIATION, JULY, 1956

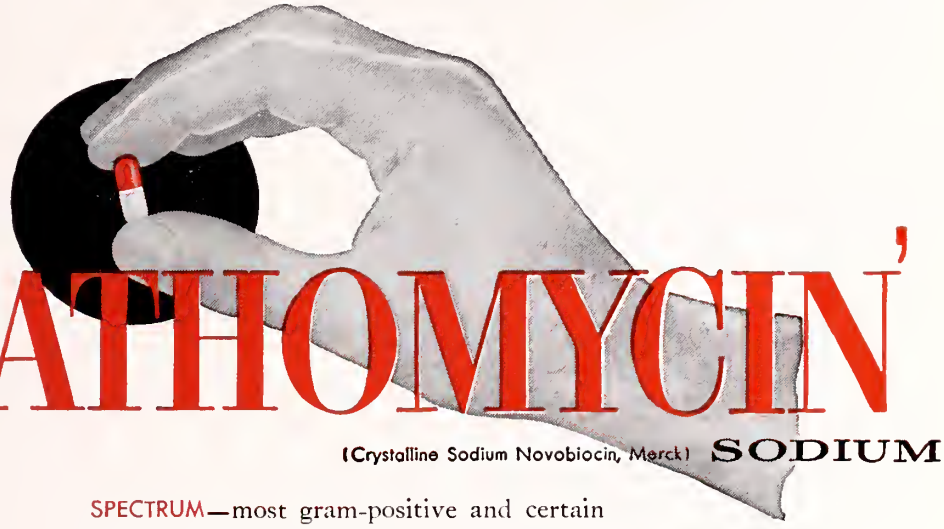
A. M. A. Directory 640
American Meat Institute 583
Ames Company, Inc., ... 651
Ayerst Laboratories 632
Bayer Aspirin 577
Brayton Pharmaceutical Co., ... 575
Geo. A. Brean & Co., ... 581
Brown & Williamson Tob. Co., ... 570
Burroughs Welcome & Co., ... 580
Ciba Pharmaceutical Co., ... 627
The Cincinnati Sanitarium 634
City View Sanitarium 628
Clearview Sanitarium 646
The Coca-Cola Company 641
Fairmount Hospital 646
Foot-So-Port Shoe Co., ... 636
Geigy Pharmaceutical Co., ... 650
The Keeley Institute 646
Lakeside Laboratories 636-644-647
Lederle Laboratories 606-607-631
Eli Lilly & Company 586
W. R. Long (Insurance Co.) 574
Louisville Med. Dental Business Bureau 646
Medical Protective Co., ... 631
Muth Optical Co., ... 646
New Castle Sanitarium 644
N. Y. Polyclinic Med. Sch. & Hosp. 643
Parke, Davis & Co., ... 562-563
Pfizer Laboratories 569-579
Physicians Casualty Ins. Co., ... 644
Pleasant Grove Hospital 626
Schering Corporation 571-584-585-645
Clayton L. Scroggins & Associates 636
G. D. Searle & Co., ... 625
Sharp & Dohme 565-566-567-576-635-639-649
Smith, Kline & French 629-652
Southern Optical Co., ... 630
E. R. Squibb & Co., ... 637
T. B. Association 640
U. S. Bond 642
Wallace Laboratories 573
Wayside Hospital 643
White Cross Hospital 582
Winthrop Laboratories 633
Wyeth, Inc., ... 638-643

NOW AVAILABLE...

a unique new antibiotic of major importance

PROVED EFFECTIVE AGAINST SPECIFIC ORGANISMS
(staphylococci and proteus)

RESISTANT TO ALL OTHER ANTIMICROBIAL AGENTS



'CATHOMYCIN'

(Crystalline Sodium Novobiocin, Merck) SODIUM

SPECTRUM—most gram-positive and certain gram-negative pathogens.

ACTION—bactericidal in optimum concentration even to resistant strains.

TOXICITY—generally well tolerated. This is more fully discussed in the package insert.

ABSORPTION—oral administration produces high and easily-maintained blood levels.

INDICATIONS—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris;* including strains resistant to all other antibiotics.

DOSAGE—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

'CATHOMYCIN' *is a trademark of Merck & Co., Inc.*

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

recognized

as a potent, specific anti-arthritic

established

by over 100 million patient days

substantiated

in more than 700 published reports

BUTAZOLIDIN®

(phenylbutazone GEIGY)

potent, specific anti-arthritic

Based on an impressive background of achievement attained over a period of four years involving both long-term and short-term therapy in all the major forms of arthritis, BUTAZOLIDIN is recognized as one of the most effective anti-arthritic agents currently available.

relieves pain

improves function

resolves inflammation

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before prescribing it.

GEIGY

GEIGY PHARMACEUTICALS, Division of Geigy Chemical Corporation, New York 13, N. Y.

72556

for results you can trust...

patients' reports you can rely on...

color
calibrated
CLINITEST®
BRAND

the urine-sugar test with the Laboratory-Controlled color scale

- clear-cut color changes in the clinically significant range
- avoids trace reactions that confuse the clinical picture
- close correlation with quantitative tests

AMES COMPANY, INC • ELKHART, INDIANA
Ames Company of Canada, Ltd., Toronto

05556

announcing . . .

Cytomel*

a new agent for treatment of

metabolic insufficiency

Because it exerts its metabolic effect directly at the cellular level, 'Cytomel' offers the first positive treatment for the many clinical problems caused by metabolic insufficiency—such as physical sluggishness, slowed-down mental capacity and decreased emotional control, and decreased function in various organs and organ systems.

'Cytomel' works swiftly—a positive effect will often be seen within several days in patients suffering from metabolic insufficiency.

'Cytomel' Tablets are available in two strengths:

5 mcg. and 25 mcg. of L-triiodothyronine, S.K.F., as the sodium salt. In bottles of 100.

LT3

*Trademark for

L-triiodothyronine, S.K.F.

Smith, Kline & French Laboratories, Philadelphia

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION

Annual Meeting Issue

See Table of Contents Page 656

KSMA
Annual Meeting
Sept. 18-20, 1956

VOLUME 54 • NUMBER 8 • AUGUST 1956



that the epileptic patient

may enjoy fuller life

DILANTIN SODIUM

(diphenylhydantoin sodium, Parke-Davis)

For patients with grand mal and psychomotor seizures,

DILANTIN — alone or in combination — continues as an anticonvulsant of choice. Effective control of seizures, with resulting greater social acceptance and increased vocational opportunities, forecasts a fuller life for such patients. DILANTIN has little or no hypnotic effect.

DILANTIN Sodium is supplied in a variety of forms — including Kapseals® of 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) in bottles of 100 and 1,000.



MILONTIN® Kapseals and Suspension

(phensuximide, Parke-Davis)

For patients with petit mal epilepsy, a drug of choice in initiating treatment — with very few and mild side effects.

MILONTIN Kapseals, 0.5 Gm., bottles of 100 and 1,000; also available as MILONTIN Suspension (250 mg. per 4 cc.) in 16-ounce bottles.

For patients with mixed grand mal—petit mal epilepsy, compatibility permits use of DILANTIN with MILONTIN.



MEDICAMENTA VERA · PD CO.

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

50060

The JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR PRO TEM: W. B. TROUTMAN, M. D. MED. EDITORIAL EDITOR: S. A. OVERSTREET, M. D.
MANAGING EDITOR: J. P. SANFORD BOOK REVIEW EDITOR: WALTER S. COE, M. D.
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D. ORGANIZATION EDITOR: BARBARA N. MORGAN
CASE DISCUSSIONS EDITOR: J. C. BELL, M. D. PRINTERS: GIBBS-INMAN, LOUISVILLE

ADVISORY COMMITTEE TO THE EDITOR

Richard J. Rust, M. D. Guy Aud, M. D., Chairman James E. Hix, M. D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1958	Term Expires July 1, 1957	Term Expires July 1, 1956
Henry B. Asman, M.D.	Carey C. Barrett, M.D.	Everett H. Baker, M.D.
Richard Elliott, M.D.	Joe Bush, M.D.	John L. Dixon, M.D.
Rankin Blount, M.D.	Allen E. Grimes, M.D.	George G. Greene, M.D.
Marion F. Beard, M.D.	Richard F. Grise, M.D.	R. Arnold Griswold, M.D.
Glenn Bryant, M.D.	Billy Keller, M.D.	O. Leon Higdon, M. D.
Douglas Scott, M.D.	A. J. Miller, M.D.	James M. Keeton, M.D.
William C. Buschemeyer, M.D.	Robert Reeves, M.D.	Frank Moore, M.D.
Harry D. Abell, M.D.	Charles R. Yancey, M.D.	Alvin C. Poweleit, M.D.

Published at 620 S. Third Street, Louisville 2, Kentucky

Subscription $8.00 per year Single Copy .80

Contents

ANNUAL MEETING SECTION

OFFICERS OF THE KENTUCKY STATE MEDICAL ASSOCIATION 680
KSMA HOUSE OF DELEGATES TO MEET SEPTEMBER 17 and 19 682
TWELVE GUEST SPEAKERS TO APPEAR ON SCIENTIFIC PROGRAMS 688
WILLIAM MCGRATH TO SPEAK AT PRESIDENT'S LUNCHEON 691
COMPLETE SCIENTIFIC PROGRAM FOR '55 SESSION ANNOUNCED 695

SCIENTIFIC ARTICLES

UROLOGIC PATHOLOGY OF INTEREST TO THE GENERAL PRACTITIONER, Frank Woods, M. D. 703
THE PAPANICOLAOU PROCEDURE AS AN AID IN THE EARLY DIAGNOSIS OF CANCER OF THE CERVIX, W. Vernon Lee, M.D. 705
VARIATIONS IN THE DISEASE, PULMONARY TUBERCULOSIS, E. M. Medlar, M.D. .707
THE MEDICAL MANAGEMENT OF LIVER DISEASE, J. Richard Gott, M.D. 710
CASE DISCUSSION 716

EDITORIALS

THE NURSING PROBLEM 718
DR. ABRAHAM FLEXNER, KENTUCKIAN 718

ORGANIZATION SECTION

Blue Shield Group Plans Seminar 719
16 Medical Students Given Loans 719
Chest Disease Symposium, August 29 719
Council Begins Plans on '57 R-H Meet 719
Alumni of UL Hospitals Have Reunion 720
Revised Medical Ethics Under Study 719
Indigent Sick May Get State Aid 720
154 Attend Annual Kenlake Seminar 720
Dr. Alley Named APS President 720
MDs from 4th District Meet July 19 722
Three MDs Re-Appointed to Committee 722
Dr. Gaither Speaks at 12th-15th Meet 722

REGULAR DEPARTMENTS

President's Page 660, In the Books 664, Washington News Digest 670, News Items 724

Second Class Mail privileges authorized at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

BETTER

results are obtained with STERANE[1]—3 to 5 times more active than hydrocortisone or cortisone.

BREATHING

capacity is greatly enhanced. "Relief of symptoms is more complete and maintained for longer periods with relatively small doses."[2]

BALANCE

of minerals and fluids usually remains undisturbed. This proves "especially advantageous in those patients with cardiac failure requiring therapy . . ."[3]

in bronchial asthma

Sterane®

brand of prednisolone



: White, 5 mg. oral tablets, bottles of 20 and 100. Pink, 1 mg. oral tablets, bottles of 100. Both deep-scored.

1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

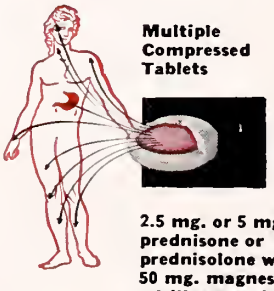
in inflammatory skin diseases



all the benefits of the "predni-steroids"
plus positive antacid action
to minimize gastric distress

ROUTINELY ACHIEVED WITH

'Co-Deltra'
(Buffered Prednisone)



Multiple Compressed Tablets

'Co-Hydeltra'
(Buffered Prednisolone)

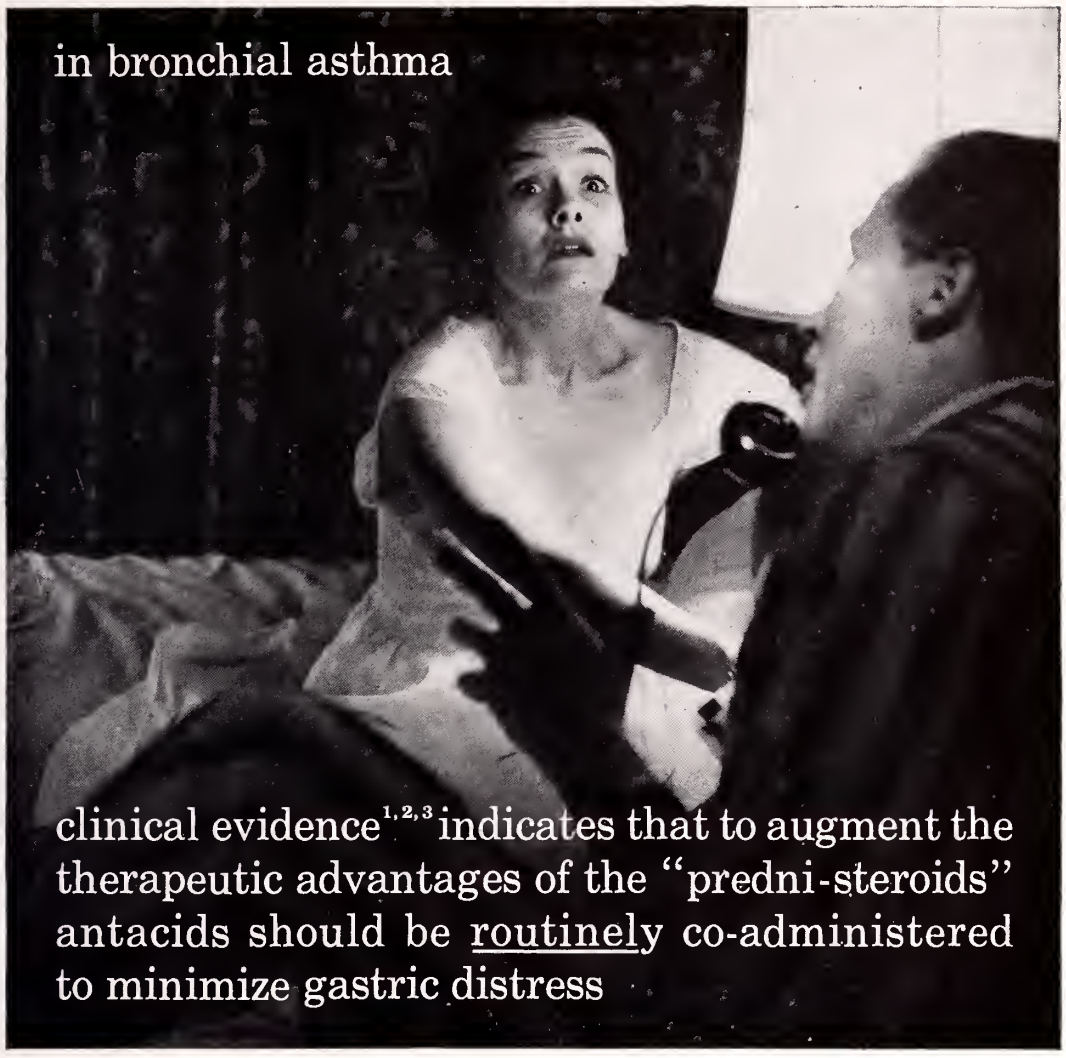
2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al, J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al, J.A.M.A.* 158:459, (June 11,) 1955.

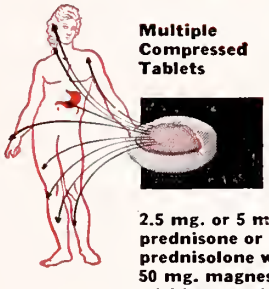
MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are the trademarks of* MERCK & CO., INC.



ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Buffered Prednisolone)



Multiple Compressed Tablets

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

'Co-Deltra'
(Buffered Prednisone)

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al, J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al, J.A.M.A.* 158:459, (June 11,) 1955.

MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are the trademarks of* MERCK & CO., INC.



message from the President

During the past 10 months I have had a great personal privilege in being your president. I have been permitted to visit each councilor district in the state. More than this I have been given the opportunity to meet with you-all socially, to know you and to banquet with you. But the real opportunity was when I was allowed to make short addresses to your groups.

In these semiformal speeches I have been allowed the chance to bring to your attention—to get into your inner minds the wedge to accentuate the values and the needs of the Kentucky State Medical Association. I hope I have been successful. I have tried.

Thank you-all very much for these courtesies.

Now, may I in turn give you an urgent invitation! It is an invitation which I hope each reader—each member of our association will feel as obligated to accept as I did the one to visit you.

It is to attend *without fail* our annual meeting in Louisville during the third week in September. I should like for every physician in the entire State to attend this meeting which is our scientific banquet for you. I came to yours, now you come to mine!

There is a great feast prepared for you, for delectation as well as development. Your committee on scientific assembly has arranged a magnificent group of distinguished experts in their specialties, to give you daily an occasion to refresh yourself along various lines in which you may feel an interest or a need.

Please do not let me down. Begin now preparing to be away from your home, let your patrons know that during that week in September you will be doing them a service by attending your state meeting. I shall enjoy seeing you there.

Gant Gaither

Gant Gaither, M. D.

anxiety is part of **EVERY ILLNESS**[1]

The physically sick patient faces two stresses—the sickness and the anxiety that it brings.[1] All too often, the anxiety is a threat to the patient's progress. It may intensify symptoms, give uncertainty to therapy, and impair rapport.

To combat the anxiety component of physical illness, EQUANIL promotes equanimity, relieves muscle tension, and encourages normal sleep.[2] By these specific actions, EQUANIL gives breadth to the treatment program—expands the physician's resources.

Supplied: Tablets, 400 mg., bottles of 50.
Usual Dose: 1 tablet, t.i.d.

1. Braceland, F.J.: Texas State J. Med. 51:287 (June) 1955.
2. Lemere, F.: Northwest Med. 54:1098 (Oct.) 1955.



E

Equanil*

Wyeth®
Philadelphia 1, Pa.

Meprobamate
(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

Licensed under U.S. Patent No. 2,724,720

*Trademark

anti-anxiety factor with muscle-relaxing action

DOCTORS EVERYWHERE NOW KNOW WHY

Viceroys Are Smoother



Professional men who have studied the microscopic analysis of the Viceroy filter now know why the Viceroy taste is smoother—never rough. Only Viceroy has 20,000 tiny filters in every tip—twice as many filters as the other two largest-selling filter brands. That is why Viceroys are smoother by far—never, never rough. That is why so many doctors now smoke and recommend Viceroys.

Yes, smoother taste because there are

TWICE AS MANY FILTERS IN EVERY VICEROY TIP

as the other two largest-selling filter brands!



Viceroy's exclusive filter is made from pure cellulose—soft, snow-white, natural!





MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.

In name
as well as
in fact

On August 1, 1956, Sharp & Dohme, the pharmaceutical and biological division of Merck & Co., Inc., adopts the name "Merck Sharp & Dohme" and a new trademark to reflect the teamwork which has already produced significant new medical products. • Developing modern medical products and making them widely available requires teamwork of the highest order in research, production, and distribution. The desire to achieve this unity of effort prompted the merger of Merck & Co., Inc., and Sharp & Dohme, Inc., three years ago. • Merck Sharp & Dohme—combining in name as well as in fact the traditions and experience of two time-honored leaders in the medicinal field—offers bright promise for further advances in helping physicians conquer disease.



MERCK SHARP & DOHME
Pharmaceuticals • Biologicals
Division of Merck & Co., INC.
Philadelphia 1, Pa.



CLINICAL RECOGNITION AND MANAGEMENT OF DISTURBANCES OF BODY FLUIDS: by John H. Bland, M.D.; 522 pages; 109 illustrations; $11.50; published by W. B. Saunders Company.

This is a practical and useful book on the recognition, diagnosis, and management of water, electrolyte, and hydrogen ion concentration disorders. Clinical signs and symptoms of fluid and electrolyte imbalance with emphasis on the bedside application are presented.

The author has taken a complicated subject, in which there is a confusing mass of information available, and he has presented the material in a concise, interesting and understanding manner. There are numerous useful illustrations to help clarify concepts that are difficult to explain in words.

The material presented in the book covers almost every medical and surgical situation in which fluid and electrolyte balance may become a problem. It is applicable especially to the internist, surgeon, and pediatrican but would be useful to every physician.

This new second edition offers three new chapters covering: pathophysiology of water and electrolyte metabolism in disease of the liver and pulmonary diseases and the metabolic consequence of head injuries.

New material in the second edition also includes mechanisms of exchange of electrolyte between intra and extra cellular water and more recent information on the mechanisms of intracellular water and electrolyte metabolism.

George W. Pedigo, M. D.

HUNTERDON MEDICAL CENTER: by Ray E. Trussell, M.D.; $3.75; 236 pages; published for The Commonwealth Fund by the Harvard University Press.

This is the history of the founding of a magnificent and unique hospital in a New Jersey farming community. Practically every aspect of the project was unusual. From the first proposal unconquerable effort and enthusiasm went into every stage of the development. The book has the suspense of fiction as one millon dollars is raised in this farming community. Disappointment is great when it is discovered that over one-half of another million is needed and must be raised before construction starts.

The book is written in a factual manner. But the term "dry" cannot be applied to it. In fact as one reads of the dynamic efforts that are displayed so often he enters the project in complete sympathy. It is an unusual experience to read this type of literature and see staunch characters so clearly revealed. The author was with the project for five years. One can hardly imagine that it could fail.

The chief of each department is an able specialist who teaches in a medical school. The internes and residents are on a rotating basis from affiliated hospitals of the New York University-Bellevue Medical Center. The interesting account is given of the relationship between the specialist and the general practitioner. In this medical center every patient admitted has a history and physical examination and is seen daily by the house staff. Even with this supervison by the house staff there is a friendly and workable relationship between the specialist and the general practitioner.

Ones education in the advances that are being made for the care of the sick is not complete without reading this book. It is as easily and entertainably read as fiction.

Julian B. Cole, M. D.

SURGERY OF THE ALIMENTARY TRACT: Volumes I, II and III, by Richard T. Shackelford, M.D., assisted by Hammond J. Dugan, M.D.; 2575 pages; 1705 illustrations; $60.00 per set; Volume I—Esophagus, Stomach and Duodenum, Liver, Gallbladder and Extrahepatic Biliary Ducts; Volume II—Pancreas, Spleen, Small Intestine (Jejunum & Ileum), Peritoneum, Omenta and Mesentery, Colon; Volume III—Anorectal Tract, Excisions of the Rectum, Hernia of the Gastrointestinal Tract, Incisions; Published by W. B. Saunders Company, Philadelphia and London, 1955.

The authors' introduction describes the development of this three-volume work. Originally projected as a replacement for the Bickham six-volume Operative Technique, the present work has been narrowed down to include only surgery of the alimentary tract, though its scope is sufficiently large to encompass nearly all abdominal surgery with the exception of the genitourinary systems. Not alone an operative surgery, this work also includes pertinent principles in the diagnosis and management of the various disorders which the described operations aim to correct. The authors include their own comments upon the advantages and disadvantages of most of the described procedures and usually indicate which they have found best.

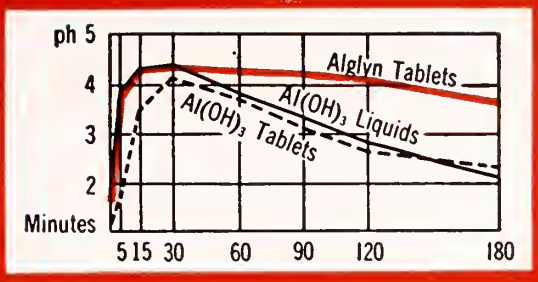
The descriptive matter is well written and easy to read. Abundant illustrations have been used and most of them are clear and graphic in their presentation of the points which they are used to illustrate. Most of them have been reproduced from papers by various authors in many publications. This leads to a certain dissimilarity in techniques, which some may find distracting in contrast with the uniform technique which might have resulted from preparation of new illustrations by a single artist. In view of the already high cost of such a publication, however, the decison against this was no doubt well justified. References to the pertinent literature are included at the end of the chapters, and these appear to be representative and well chosen. Typography and format are of the best.

It is impossible, with such a lengthy work, to consider in detail any of the individual parts. Suffice it to say that this is the most complete and up-to-date operative treatise covering the surgery of the alimentary tract presently available. It should prove to be an invaluable reference work, not only for surgeons, but for all physicians concerned with the diagnosis and management of disorders of the digestive system.

Rudolf J. Noer, M. D.

The Life Insurance Medical Research Fund recently announced it has awarded $960,340 in grants and fellowships to aid research on heart disease this year. This brings the Fund's total contributions since 1945 to $8,161,170.

Announcing Revision of N.N.R. Monograph for



ALGLYN®

dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayton PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

Doctor Disabled

OFFICE EXPENSE CONTINUES

At last, here is the practical solution to this problem - - - an insurance policy to pay your expenses, with the premium eligible as a Tax Deduction.

Latest Tax ruling provides that premiums on Health and Accident insurance are not deductible unless the policy states that it is for the express purpose of meeting business overhead expenses.

Ask your Accountant or Lawyer about this question and then ask us to explain this coverage.

W. R. LONG & ASSOCIATES
1534 Bardstown Road—Louisville, Ky.

Without obligation to me I would like to have more information on your office expense policy. I am in good health and was

born .....
Month Day Year

Name .....

Address .....

Plan Now

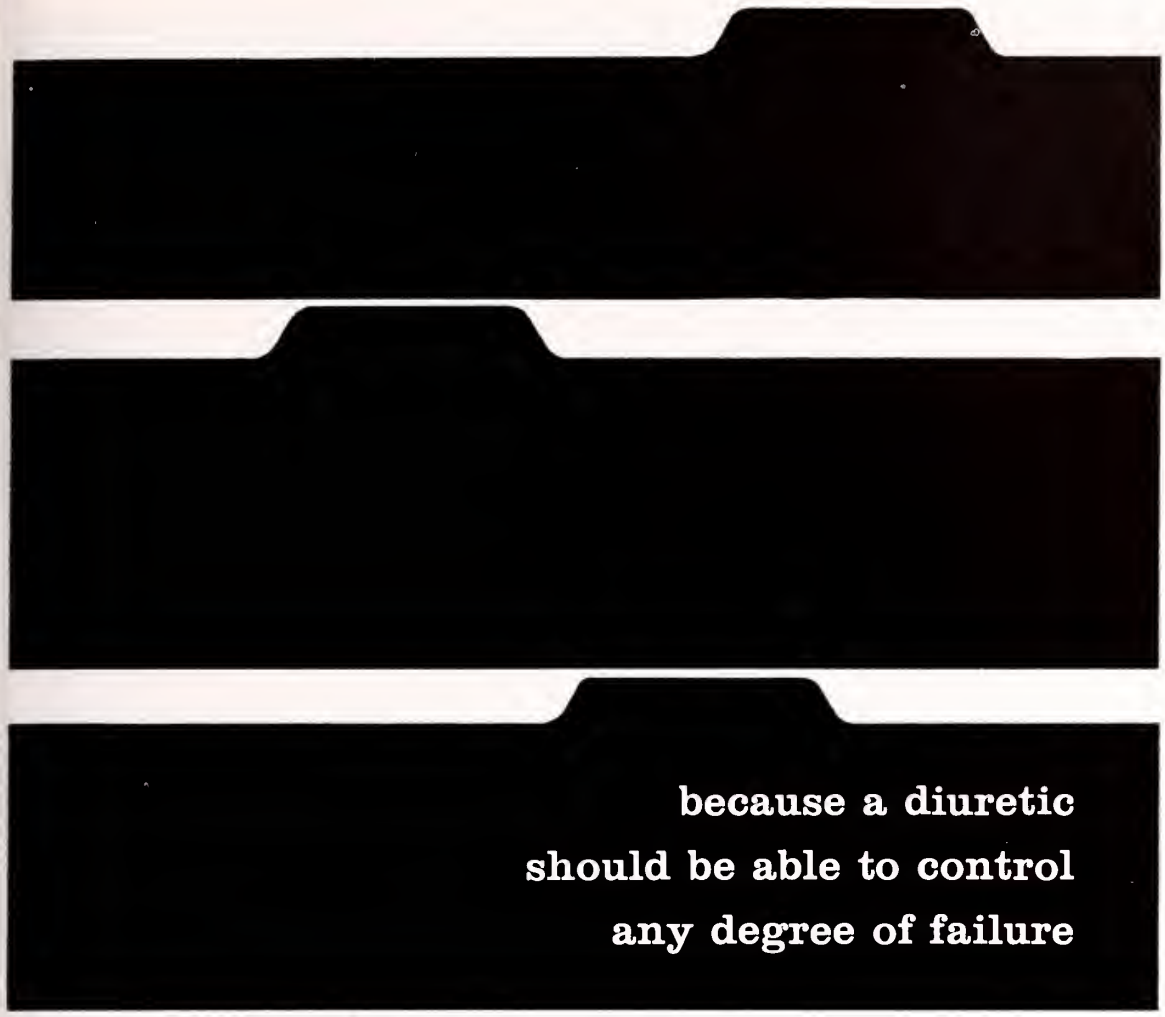
to attend the

1956 KSMA ANNUAL MEETING

Columbia Auditorium
Louisville

Sept. 18-19-20

- 12 nationally known guest speakers
- three six hour refresher courses
- carefully selected scientific movies
- outstanding scientific exhibits
- 64 technical exhibits
- other top features



PATIENTS IN FAILURE NEED AN ORGANOMERCURIAL

Certain diuretics are apt to mask the gradual onset of severe failure because they are effective only in the milder ambulatory cardiacs. The recurrent accumulation of fluid permitted by intermittent or arbitrarily limited dosage must eventually progress to more severe decompensation.

Because they can control *any* grade of failure, the organomercurials improve prognosis and prolong life.

TABLET

NEOHYDRIN®

BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure

MERCUHYDRIN® SODIUM

BRAND OF MERALLURIDE INJECTION

01356

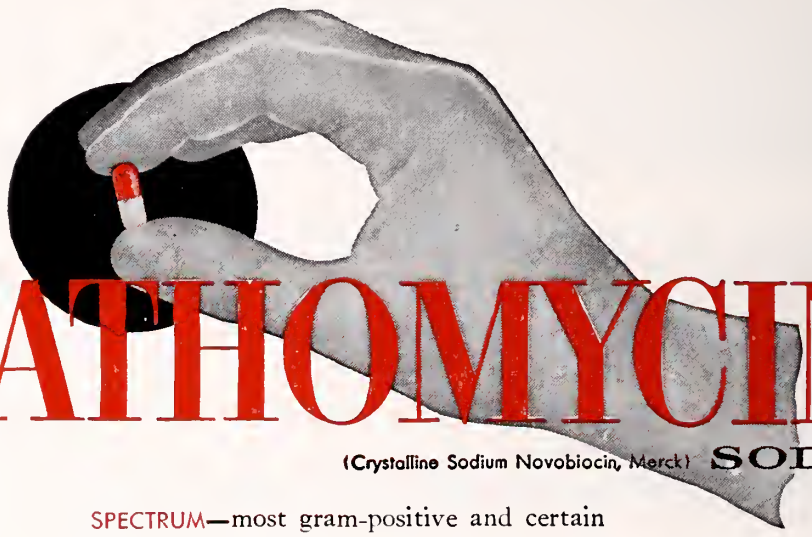
LAKESIDE

NOW AVAILABLE...

a unique new antibiotic of major importance

PROVED EFFECTIVE AGAINST SPECIFIC ORGANISMS
(staphylococci and proteus)

RESISTANT TO ALL OTHER ANTIMICROBIAL AGENTS



'CATHOMYCIN' SODIUM

(Crystalline Sodium Novobiocin, Merck)

SPECTRUM—most gram-positive and certain gram-negative pathogens.

ACTION—bactericidal in optimum concentration even to resistant strains.

TOXICITY—generally well tolerated. This is more fully discussed in the package insert.

ABSORPTION—oral administration produces high and easily-maintained blood levels.

INDICATIONS—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris*, including strains resistant to all other antibiotics.

DOSAGE—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

'CATHOMYCIN' *is a trademark of Merck & Co., Inc.*

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.



KARO® SYRUP . . . meets the need for individualized infant formulas

In meeting the nutritional needs of formula-fed infants, the methods used are dependent upon the digestive capacity and tolerance of each infant.

But, whether the formula calls for sweet, acid, evaporated, dried or protein milk—Karo syrup meets the need for a well-tolerated and easily digested source of carbohydrate. This fluid mixture of dextrins, maltose and dextrose is completely utilized without inducing flatulence, colic, fermentation or allergy.

Either light or dark Karo may be used in prescribing formulas for infants because of equivalent digestive and nutritive values. Each fluid ounce (2 tablespoonfuls) yields 120 calories.

Mothers will appreciate the ease of making formulas with Karo syrup... as well as its ready availability and economy.



1906 • 50th ANNIVERSARY • 1956
CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N. Y.



WASHINGTON NEWS DIGEST



Washington, D. C.—If medical research doesn't move ahead in the current fiscal year (ending June 30, 1957), it won't be the fault of Congress. The seven research organizations that make up the National Institutes of Health have far more money than they have ever had, and probably much more than their directors even dared hope for last winter at the start of hearings on their budgets. Every one of the research institutes received a substantial increase over last year, and the funds of five of them were almost doubled.

The Institutes have a total of $170.4 million to spend before next July 1. This is about 80 per cent more than they had last year. In discussing the appropriations bill on the Senate floor, Senator Lister Hill (D., Ala.) said the bulk of the money will go for grants to non-federal institutions—hospitals, medical schools, clinics and state and local organizations engaged in research.

A breakdown by disease categories shows the following picture:

For cancer research, $48.4 million, in contrast to $24.8 million for the previous year. This year's total is $16 million more than the administration asked when budget requests were sent to Congress in January.

For mental health work, $35.1 million, in contrast to last year's $18 million. This is $13.4 million more than had been requested originally.

For heart disease research, $33.3 million, compared with $18.7 million last year and $22.1 million originally requested.

For work on arthritis and metabolic diseases, $15.8 million, or $5.1 million more than last year and $2.5 million more than Congress was asked for.

For research in neurology and blindness, $18.6 million, compared with $9.8 million last year and $12.1 million originally requested.

For work on allergies and infectious diseases, $13.2 million, compared with $7.5 million last year and $9.7 requested.

For dental research, $6. million. While this is small compared with money voted for other US research institutes, it is almost triple the $2.1 million spent last year. The huge increase is the result of a sustained campaign by the American Dental Association.

Senator Hill and Rep. John E. Fogarty (D., R. I.) led the fight in Congress for the record-breaking research appropriations. Under the latter's chairmanship, a House appropriations subcommittee boosted the total for the seven institutes to about $124 million, a figure that was accepted both by the full Appropriations Committee and the House.

In addition to heading the Senate appropriations subcommittee that handled this funds bill, Senator Hill also is chairman of the Labor and Welfare Committee and extremely active in health legislation. His subcommittee pulled up the totals to the $170 million. After the Senate-House conference committee disagreed on the spending, Rep. Fogarty carried the fight to the floor, where he persuaded the House to accept all of the higher Senate figures.

Other federal health programs, mainly concerned with disease control and hospital construction, also fared well with the Congress. The Hill-Burton program, for construction grants to hospitals, has $125 million for the current year, or $14 million more than last year. For vocational rehabilitation grants, the figure is $41.5 million, a $2.7 million increase; for general public health assistance to states, it is $18.16 million, a $600,000 increase; for Indian health work, it is $38 million, a $3.3 million increase.

NOTES:

With Salk vaccine being released in ever expanding volume, the Public Health Service is urging states and communities to increase the priority age to 20 and to use up supplies as fast as received. Said Secretary Folsom: "I urge parents, physicians, and health officials to cooperate in making the maximum use of the increasing supply as soon as it becomes available . . . "

Civil Aeronautics Administration, believing the time has come to review procedures in pilot medical examinatons has hired a private organization to conduct a thorough investigation and make recommendations. Two questions: Should lower standards be allowed for older, experienced pilots? Should crew members and ground crewmen, as well as pilots, be examined periodically?

Less than three months after his third appointment to a four-year term as Surgeon General of U.S. Public Health Service, Leonard Scheele, M. D., resigned to take a post in the pharmaceutical industry so he could "provide more properly" for his family.

Although no new legislation was enacted in that field, witnesses at a long series of hearings on civil defense were pretty much in agreement that the job can't be done properly unless more authority is voted to the Federal Civil Defense Organization.



new Peach-flavored, peach-colored, newest liquid form of the established broad-spectrum antibiotic... TERRAMYCIN®† 125 mg. per 5 cc. teaspoonful; specially homogenized for rapid absorption; bottles of 2 fl. oz. and 1 pint, packaged ready to use.

delightful peach taste in broad-spectrum therapy

TERRABON®

BRAND OF OXYTETRACYCLINE

HOMOGENIZED MIXTURE

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y. Pfizer

†Brand of oxytetracycline

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

Against the "Vaginitis Spectrum"

TRICHOMONAS
MONILIA
BACTERIA

A welcome clinical advance...
effective medication
in an appealing form



Soft and pliant as a tampon, the Milibis vaginal suppository offers proved therapeutic action* in a vehicle giving unusual clinical advantages to both patients and physician.

COVERS CERVIX AND VAGINAL WALL—The pliant Milibis suppository disintegrates readily and molds itself to the cervix as well as the columns and rugae of the vaginal vault.

SHORT DOSAGE SCHEDULE—The short course of treatment with Milibis—only 10 suppositories in most cases—together with the clean, odorless, non-staining qualities eliminates psychic barriers which often interrupt longer treatments before complete cure.



MILIBIS® Vaginal Suppositories

Supplied: boxes of 10

Winthrop LABORATORIES
New York 18, N. Y.

*97 per cent effective in a study of 564 cases; 94 per cent effective in a series of 510 cases.

Milibis (brand of glycobiarsol), trademark reg. U. S. Pat. Off.

The BROWN HOTEL is prou
for the KENTUCKY STAT

No men in this entire State work under more strain or pressure than the members of the Kentucky Medical Profession.

No men are of greater VALUE to all the people of this Commonwealth.

Hence, during the endless hours of their "work days", and during their few priceless minutes outside their professional duties, Doctors DESERVE the utmost in comfort, convenience and friendly service, in the hotels and restaurants they patronize.

be HEADQUARTERS
EDICAL ASSOCIATION

Under the circumstances, the Brown Hotel is more than proud of the fact that we have always been chosen as HEADQUARTERS for the Kentucky State Medical Association—not only during Convention-time, but EVERY DAY OF THE YEAR.

We feel that we owe you not only our best "hospitality", but also our deepest respect and our warmest friendship. And, in some cases, our lives. . . .

For all these reasons, now and always—WELCOME TO THE BROWN HOTEL.

Harold E. Harter
Managing Director

new dimensions in the treatment of sever



broadens benefits

- rapid control of allergic sneezing, lacrimation, nasal congestion; relief of pruritus, edema and erythema
- up to 5 times more effective than oral hydrocortisone, milligram for milligram

narrows side effects

- minimizes incidence of fluid and electrolyte disturbance
- dietary regulation usually unnecessary

lengthens established gains

- permits a smoother, undisturbed regimen
- extends and maintains benefits to more patients

ıy fever and other difficult allergies...

METICORTEN*

(PREDNISONE)

for outstanding hormonal control
with minimal electrolyte disturbances

in hay fever and other respiratory allergies,
contact dermatitis and allergic eczemas,
drug and other allergic reactions,
allergic and inflammatory eye disorders



METICORTEN,* brand of prednisone. *T.M.
1, 2.5 and 5 mg. tablets. MC-J-3086

Schering

prevents postpartum hemorrhage
speeds uterine involution



'Ergotrate Maleate'

(ERGONOVINE MALEATE, LILLY)

. . . produces rapid and sustained contraction of the postpartum uterus

'Ergotrate Maleate' almost completely eliminates the incidence of postpartum hemorrhage due to uterine atony. Administered during the puerperium, 'Ergotrate Maleate' increases the rate, extent, and regularity of uterine involution; decreases the amount and sanguineous character of the lochia; and decreases puerperal morbidity due to uterine infection.

Supplied:

Ampoules of 0.2 mg. in 1 cc.
Tablets of 0.2 mg.

DOSAGE: Generally, 0.2 to 0.4 mg. I.V. or I.M. immediately following delivery of placenta. Thereafter, 0.2 to 0.4 mg. three or four times daily for two weeks.

80TH ANNIVERSARY 1876 · 1956 / ELI LILLY AND COMPANY

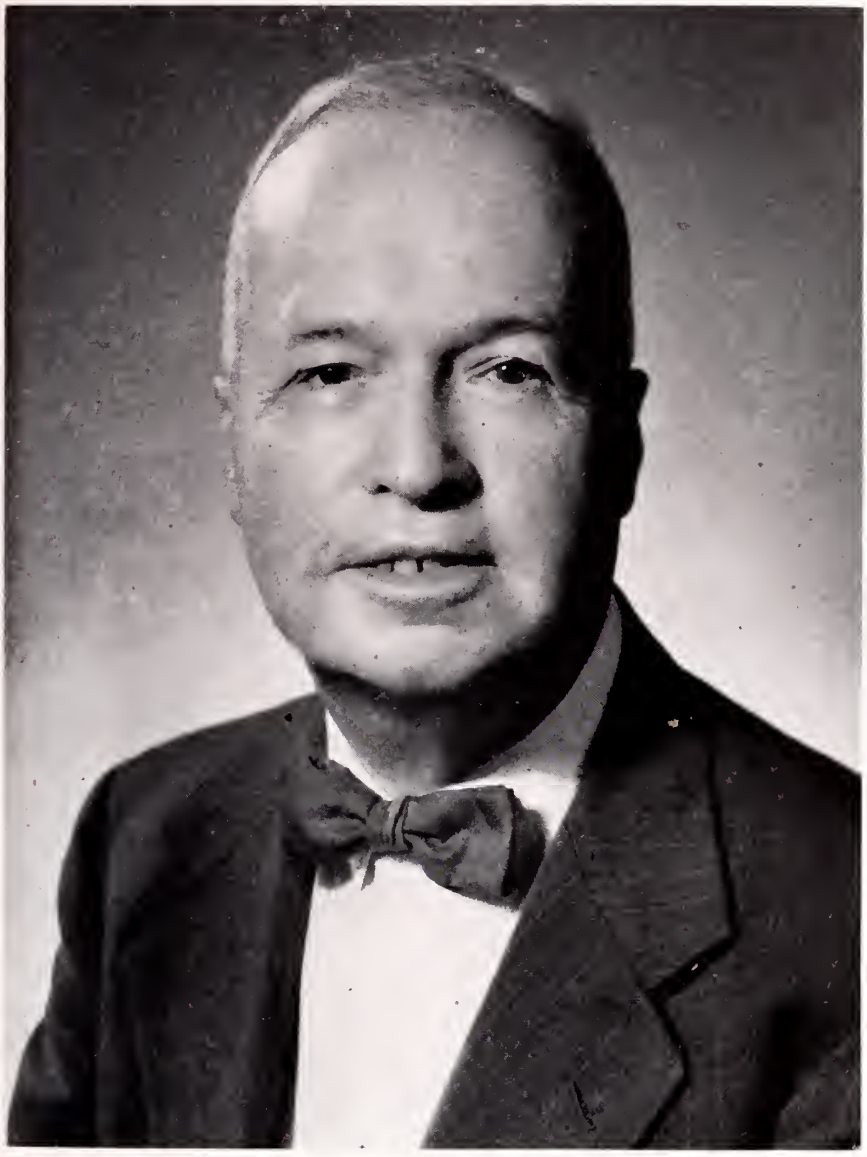
659004

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

NO. 8 AUGUST, 1956 VOL. 54

OFFICERS OF KENTUCKY STATE MEDICAL ASSOCIATION



GANT GAITHER, M.D.
President

RICHARD R. SLUCHER, M.D.

President-elect

Dr. Slucher, Louisville internist, will become the seventieth president of the Kentucky State Medical Association at the close of the 1956 Annual Meeting, September 20.

Born May 25, 1905, Dr. Slucher is a native of Anderson County. After graduation in 1926 from the University of Louisville with a BS in medical science, he entered the University of Louisville School of Medicine. He received his medical degree in 1930. In 1929 he became a member of the Alpha Omega Alpha fraternity.

Dr. Slucher interned at the Louisville General Hospital. From 1931 to 1935 he served a residency in medicine at the General Hospital and Long Island College and Hospital in New York.

After completion of his residency in '35 he became clinical instructor of medicine at the University of Louisville Medical School. Also in the same year he began private practice in Buechel.

In 1942 after the outbreak of World War II Dr. Slucher joined the Navy. He served as a commander in the medical corps. He was discharged in 1946 and returned to his practice in Buechel.

In 1940 Dr. Slucher married Emma Hood of Greensburg. They have no children.

Dr. Slucher is past president of the Jefferson County Medical Society and the staff of the Kentucky Baptist Hospital. He is a former chairman of the Jefferson County Medical Society's Board of Governors.

He is a member of the Louisville Society of Internists and is a past president of the Kentucky Academy of General Practice.

Always active in the Kentucky State Medical Association, Dr. Slucher was a member of the Council from 1947 to 1955. He has served on the Executive Committee of the KSMA Council for three years. He is chairman of the Committee on Arrangements and a member of the KSMA Committee on Scientific Assembly and Committee to Study Relations With Voluntary Health Groups.

During his post-graduate training, Dr. Slucher, who has a warm and friendly disposition, demonstrated his capacity as a leader when he served as the chief resident in medicine at the then Louisville City Hospital. The intervening years have seen his colleagues give him more and more responsibility as he moved from one position of leadership to another.

While president of the Jefferson County Medical Society, Dr. Slucher attracted attention on a national basis in organized medical circles when the society modernized its organization, expanded its services and appointed an executive secretary.

Because of his deep loyalty to his profession, his willingness to accept responsibility and the effective way he discharges it, plus his broad experiences as a leader, the House of Delegates felt in choosing Dr. Slucher it was living up to the standards it had met in the past by electing an outstanding man for this most important position.

Vice-Presidents

EVERETT H. BAKER, M.D.

Louisville



Dr. Baker, a graduate of Vanderbilt University and the University of Louisville School of Medicine, was born in Louisville March 30, 1903. He began a practice in Louisville in 1927.

From 1942 to 1946 he served in the US Air Force. During this time he did post graduate work in anesthesiology at Mayo Clinic and Flower Hospital in New York.

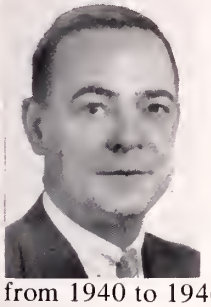
Dr. Baker, a graduate of Vanderbilt Univer- Society of Anesthesiologists, is a diplomate of the American Board of Anesthesiology. He is chief of the anesthesia section at St. Joseph Infirmary, consultant in anesthesia at Veterans Hospital and Army Hospital, Fort Knox.



R. R. Slucher

PRESIDENT KENTUCKY STATE MEDICAL ASSOCIATION 1956

N. LEWIS BOSWORTH, M.D.
Lexington



Dr. Bosworth received his medical degree in 1933 from the Medical Department of the University of Virginia. He interned in New York at the Post-Graduate Hospital.

From 1933 to 1937 he served two residencies — one in surgery at the New York Post - Graduate and the other in urology at the Jersey City Medical Center. He served in the US Army from 1940 to 1946.

Dr. Bosworth, a diplomate of the American Board of Urology, is immediate past president of the Fayette County Medical Society and the staff of the St. Joseph Hospital.

HOWELL J. DAVIS, M.D.
Owensboro



Dr. Davis was born in Whitley County, February 16, 1908. He was graduated summa cum laude from the University of Kentucky in 1929. He received his medical degree from the University of Pennsylvania.

He served a two year internship at the University Hospital and a surgical residency at St. Joseph Infirmary. In 1936 he started a practice in Owensboro. He was called into the military service in 1941 and served four and one-half years.

Dr. Davis is a member of Daviess County Medical Society, KSMA, AMA, Southeastern Surgical Congress, American College of Surgeons and the Kentucky Surgical Society. He is chief of surgical services at the Owensboro-Daviess County Hospital.

Secretary-Editor Pro tem
WOODFORD B. TROUTMAN, M.D.
Louisville

Dr. Troutman, KSMA treasurer since 1946, has served as secretary-editor pro tem of the Association since January 5. He was named to the office after the resignation of Bruce Underwood, M.D. Dr. Underwood resigned to take a position with the United States Public Health Service in Washington, D. C.

Treasurer
WOODFORD B. TROUTMAN, M.D.
Louisville



Dr. Troutman, a native of Bullitt County, has been treasurer of the Kentucky State Medical Association for the past 10 years. He was first elected by the House of Delegates April 17, 1946.

Dr. Troutman was graduated from the University of Louisville School of Medicine in 1921. He interned at McKeesport Hospital in Pennsylvania and Bellevue Hospital in New York.

In 1929 he left Louisville where he had practiced general medicine for five years, and studied in Vienna, London and Edinburg. He returned to Louisville in 1930 and began a practice of cardiology. He served in the Army Air Force in World War II.

Speaker
CHARLES A. VANCE, M.D.
Lexington



This year marks the end of Dr. Vance's first three-year term as Speaker of the House of Delegates. He served as vice speaker up to 1953.

President of the KSMA in 1948, Dr. Vance has for many years been chairman of the McDowell Home Committee. In 1955 he was chairman of the Professional Relations Committee and a member of the Medical School Advisory Committee.

Born in 1880, Dr. Vance was graduated from the Medical Department of Kentucky University in 1903. A founder and charter member of the Kentucky Surgical Society, Dr. Vance is a member of the Southern Surgical Association, the American College of Surgeons and the American Association for the Surgery of Trauma.

Vice-Speaker

E. W. JACKSON, M.D.
Paducah

Dr. Jackson was elected to the office of vice-speaker of the Kentucky State Medical Association in 1953. Previously in 1946, he had served as president of the Association.



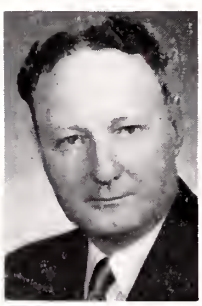
In addition to his KSMA activities, Dr. Jackson is past president of the Southwestern Kentucky Medical Society and the Kentucky Surgical Society. He is a member of the Southeastern Surgical Congress and the American College of Surgeons.

A 1912 graduate of the Medical Department of the University of Louisville, Dr. Jackson, who was president of his graduating class, interned at Louisville General Hospital and Eastern Indiana Hospital.

Delegates to the AMA

W. CLARK BAILEY, M.D.
Harlan

Dr. Bailey, a physician in his birthplace, Harlan since his graduation from medical school in 1926, has been a KSMA delegate to the AMA since 1944. He was vice-president of the AMA in 1954-55.



President of the KSMA in 1951, Dr. Bailey, is a member of the AMA's legislative committee and the Committee on Medical Care of Workers in the Bituminous Coal Mining Area. He has also served on many KSMA committees.

Dr. Bailey is a graduate of the University of Louisville School of Medicine. He took his hospital training at the Tuberculosis Hospital in Louisville, the Children's Hospital and Louisville City Hospital.

W. VINSON PIERCE, M.D.
Covington

Dr. Pierce was named a delegate to the AMA at the 1955 meeting of the KSMA House of Delegates. Prior to that time he had been an alternate delegate.



A native of Catlettsburg, Dr. Pierce is a 1934 graduate of the University of Louisville Medical School. He interned at St. Elizabeth Hospital in Covington and the Louisville City Hospital. He served a residency in urology at the City Hospital.

A major in the medical corps during World War II Dr. Pierce, who limits his practice to urology, is now president of the Kentucky Physicians Mutual, Inc., and immediate past president of the Kentucky Chapter of the American College of Surgeons.

KSMA House of Delegates to Meet Sept. 17 and 19

The KSMA House of Delegates will hold its first 1956 meeting during the Annual Meeting, September 17 at 7 PM in the Columbia Auditorium. Registration will begin at 6 PM.

Reports and new business in the form of resolutions will be introduced at the first session, according to Charles Vance, M.D., Lexington, speaker of the House. After introduction, these matters will be assigned to reference committees who will meet on Tuesday afternoon.

The Delegates will hold their second session Wednesday night, September 19 at the same time. At this time the reference committees will present their recommendations on the reports and final actions will be taken.

At this second session the general officers and councilors will be elected.

Following are a list of the KSMA delegates:

Adair:	James C. Salato, Columbia
Allen:	J. W. Meredith, Scottsville
Anderson:	Boyd Caudill, Lawrenceburg
Ballard:	H. G. Sargent, Barlow
Barren:	Clifton G. Follis, Glasgow
Bath:	H. S. Gilmore, Owingsville
Bell:	David C. Asher, Pineville
Boone:	G. L. Rouse, Florence
Bourbon:	Jesse Smith, Paris
Boyd:	H. E. Martin, Ashland
Boyle:	Chris Jackson, Danville
Bracken:	C. A. Marquardt, Augusta
Breathitt:	
Breckinridge:	W. H. Brown, Irvington
Bullitt:	
Butler:	D. G. Miller, Morgantown
Caldwell:	F. P. Giannini, Princeton

Calloway:	A. D. Butterworth, Murray
Campbell-Kenton:	Norman Adair, Covington
	Carl Kumpe, Ft. Mitchell
	J. J. Rolf, Covington
	Robert Hoffmann, Ft. Mitchell
	Marc Reardon, Covington
Carlisle:	J. F. Harrell, Bardwell
Carroll:	E. S. Weaver, Carrollton
Carter:	J. Watts Stovall, Grayson
Casey:	K. R. Adams, Liberty
Christian:	Charles Yancey, Hopkinsville
Clark:	Charles F. Martin, Winchester
Clay:	W. E. Becknell, Manchester
Clinton:	E. A. Barnes, Albany
Crittenden:	
Cumberland:	Joseph Schickel, Burksville
Daviess:	A. B. Colley, Owensboro
Edmonson:	S. E. Farmer, Brownsville
Elliott:	John F. Greene, Sandy Hook
Estill:	S. G. Marcum, Irvine
Fayette:	R. G. Elliott, Lexington
	C. C. Johnson, Lexington
	N. L. Bosworth, Lexington
	John W. Scott, Lexington
	T. L. Adams, Lexington
	Carl Fortune, Lexington
	R. C. Blount, Lexington
Fleming:	R. W. Fidler, Flemingsburg
Floyd:	M. V. Wicker, Wayland
Franklin:	Esten S. Kimbel, Frankfort
Fulton:	R. Ward Bushart, Fulton
Gallatin:	George Harris, Warsaw
Garrard:	V. G. Kinnaird, Lancaster
Grant:	
Graves:	Robert Orr, Mayfield
Grayson:	Clyde Nichols, Clarkson
Green:	J. W. Miller, Greensburg
Greenup:	J. G. Boggs, Russell
Hancock:	
Hardin:	W. A. Litzenberger, Elizabethtown
Harlan:	E. M. Howard, Harlan
	Philip J. Begley, Harlan
Harrison:	J. P. Wyles, Cynthiana
Hart:	Fred J. Cecil, Horse Cave
Henderson:	J. L. Tanner, Henderson
Henry:	W. P. McKee, Eminence
Hickman:	V. A. Jackson, Clinton
Hopkins:	L. C. Trover, Madisonville
Jackson:	
Jefferson:	R. H. Akers, Louisville
	W. C. Buschemeyer, Louisville
	F. D. Coleman, Louisville
	W. B. Davis, Louisville
	R. S. Dyer, Louisville
	A. H. Keeney, Louisville
	J. S. Llewellyn, Louisville
	A. O. Miller, Louisville
	Houston W. Shaw, Louisville
	U. R. Ulferts, Louisville
	Rudy Vogt, Louisville
	John Allen, Louisville
	W. H. Bizot, Louisville
	G. W. Bryant, Louisville
	Blaine Lewis, Louisville
	R. C. Long, Louisville
	H. B. Martin, Louisville
	R. H. Moore, Jr., Louisville
	R. F. Monroe, Louisville
	John Bell, Louisville
	John Weeter, Louisville
	Carroll Witten, Louisville
	Samuel Smith, Louisville
Jessamine:	J. S. Williams, Nicholasville
Johnson:	
Knott:	M. F. Kelley, Hindman
Knox:	T. R. Davis, Barbourville
Larue:	J. D. Handley, Hodgenville
Laurel:	S. M. Adams, London
Lawrence:	J. E. Carter, Louisa
Lee:	J. M. Smith, Beattyville
Leslie:	
Letcher:	Carl Pigman, Whitesburg
Lewis:	
Lincoln:	M. M. Phillips, Crab Orchard
Livingston:	
Logan:	G. L. Richardson, Adairville
Lyon:	J. E. Cotthoff, Kuttawa
Madison:	Douglas Jenkins, Richmond
Magoffin:	
Marion:	Eli George, Lebanon
Marshall:	George McLain, Benton
Martin:	
Mason:	C. G. Prindle, Maysville
McCracken:	Leon Higdon, Paducah
McCreary:	M. D. Haley, Stearns
McLean:	W. G. Edds, Calhoun
Mead:	
Menifee:	D. L. Graves, Frenchburg
Mercer:	T. D. Meredith, Harrodsburg
Metcalfe:	E. S. Dunham, Edmonton
Monroe:	T. L. Carter, Tompkinsville
Montgomery:	J. M. Bush, Mt. Sterling
Morgan:	Alec Spencer, West Liberty
Muhlenberg:	H. H. Woodson, Greenville
Nelson:	K. L. Stinnette, Bardstown
Nicholas:	B. F. Reynolds, Carlisle
Ohio:	Oscar Allen, Beaver Dam
Oldham:	J. T. Walsh, LaGrange
Owen:	Maurice Bowling, Owenton
Owsley:	W. B. Gabbard, Booneville
Pendleton:	W. M. Townsend, Falmouth
Perry:	C. C. Rutledge, Hazard
Pike:	Adam Osborne, Pikeville
Powell:	
Pulaski:	Brent Weddle, Somerset
Robertson:	Perry Overby, Mt. Olivet
Rockcastle:	R. G. Webb, Livingston
Rowan:	
Russell:	M. M. Lawrence, Jamestown
Scott:	H. G. Wells, Georgetown
Shelby:	Don Chatham, Shelbyville
Simpson:	L. F. Beasley, Franklin
Spencer:	W. H. Skaggs, Taylorsville
Taylor:	W. R. Mann, Mannsville
Todd:	R. D. Lynn, Elkton
Trigg:	John Futrell, Cadiz
Trimble:	Carl Cooper, Jr., Bedford
Union:	G. B. Carr, Sturgis
Warren:	J. T. Gilbert, Jr., Bowling Green
Washington:	M. A. Coyle, Springfield

Wayne:	F. L. Duncan, Monticello
Webster:	
Whitley:	K. P. Smith, Corbin
Wolfe:	
Woodford:	George H. Gregory, Versailles

KSMA Officers to be Elected at Second Session of House

The KSMA House of Delegates will elect the Association's 1956-57 officers at the second session of the House, September 19. Offices to be filled are:

President-elect: (Eastern Section) one year

Vice Presidents: (Central, Eastern and Western Sections) one year

Secretary: (to fill the unexpired term of Bruce Underwood, M.D.) two years

Speaker of the House: (Charles Vance, M.D., Lexington) three years

Vice Speaker: (E. W. Jackson, M.D., Paducah) three years

Delegate to the AMA: (W. Clark Bailey, M.D., Harlan) two years

Alternate delegate to the AMA: two years

(Incumbent officers are listed in parentheses).

According to By-law provisions the Nominating Committee, which was named at the final meeting of the 1955 Session, will announce its candidates at the beginning of the Second Scientific Session on Tuesday afternoon September 18. The House of Delegates will vote on these nominees at the second session. Additional nominations can be made from the floor.

Chairman Pace to Read Report of KSMA Council Sept. 17

Actions taken during the 1955-56 associational year by the KSMA Council and its Executive Committee will be reported to the House of Delegates on Monday night, September 17 at the initial session by J. Vernon Pace, M.D., Paducah, chairman.

The report will demonstrate anew the great amount of responsibility the members of the Council must assume in looking after the association's affairs between meetings of the House of Delegates.

The Executive Committee of the Council has held four day-long meetings and the Council has held five sessions, prior to the meeting scheduled for Monday afternoon, September 17.

With the elevation of Richard R. Slucher, M.D., Louisville, to the office of President-elect, at the end of the first year of a three year term as councilor of the Fifth District, the House of Delegates in 1955 elected Carlisle Morse, M.D., Louisville, to fill the vacancy.

The House also elected in 1955 the following five councilors to succeed themselves for three year terms: Walter L. O'Nan, M.D., Henderson, Second District; Branham B. Baughman, M.D., Frankfort, Seventh District; J. M. Stevenson, M.D., Brooksville, Ninth District; J. Farra Van Meter, M.D., Lexington, Tenth District and Charles B. Johnson, M.D., Russell, Thirteenth District.

CARLISLE MORSE, M.D.
Louisville
Fifth District

Dr. Morse, a native of Caldwell County, is a graduate of Western Kentucky Teachers College and Swarthmore College. He received his medical degree in 1930 from the University of Louisville School of Medicine.

He spent four years at the Louisville General Hospital in a rotating internship and residencies in psychiatry and medicine. Now he is assistant professor of medicine at the University of Louisville.

A member of the KSMA, AMA, and SMA, Dr. Morse is a fellow of the American College of Physicians. He is Governor for Kentucky for the American Diabetes Association, and chairman of the KSMA Diabetes Committee. Dr. Morse is past secretary and treasurer of the Jefferson County Medical Society.

Seven Reference Committees to Operate at '56 Meeting

Having as its purpose to provide each Reference Committee with more time for consideration of the various reports of committees and officers made to the House of Delegates two new reference committees will be in operation at the 1956 Annual Session.

Charles A. Vance, M.D., Lexington, speaker of the House, said that the KSMA Council had authorized him to name seven reference committees instead of five to handle the work of the 1956 meeting. The new committees will meet in the same room and at the same time the original five have met for years, Dr. Vance said.

Dr. Vance outlined the duties of the committees as follows:

1. At the first meeting of the House of Delegates on September 17, the 60-odd reports of the officers, council and KSMA committees and agencies which are made to the House will be referred to one of the seven reference committees.

2. The members of the Reference committees will meet in the reference committee room

COUNCILORS

First District



J. VERNON PACE*•
Paducah

Second District



WALTER O'NAN
Henderson

Third District



DELMAS M. CLARDY*
Hopkinsville

Fourth District



W. KEITH CRUME
Bardstown

Fifth District



CARLISLE MORSE
Louisville

Sixth District



L. O. TOOMEY
Bowling Green

Seventh District



B. B. BAUGHMAN
Frankfort

Eighth District



EDW. B. MERSCH
Covington

Ninth District



J. M. STEVENSON
Brooksville

Tenth District



J. F. VAN METER
Lexington

Eleventh District



HUGH MAHAFFEY*
Richmond

Twelfth District



GARNETT J. SWEENEY*
Liberty

Thirteenth District



CHARLES B. JOHNSON
Russell

Fourteenth District



JOHN ARCHER
Prestonsburg

Fifteenth District



CHARLES B. STACY
Pineville

* Member, Executive Committee

• Chairman

at Columbia Auditorium at 1:45 p.m. Tuesday for a short briefing session. They will go into session at 2 p.m.

3. The Committees will hold hearings for two hours. During this period any member of the KSMA who wants to be heard on one or more issues before the House is urged to be present and make his views known. Dr. Vance said if the member did not know where to go to be heard to contact him, any KSMA officer or member of the Headquarters staff.

4. The reference committees will go into executive session following the hearings. During this session the committees will study the reports, review the testimony heard, and decide on recommendations on the reports assigned to them.

5. The final duty of the Committees is to present the recommendations on the reports at the final meeting of the Delegates, Wednesday, September 19.

Following are the names of the delegates who will make up the reference committees and the names of those who will serve on the Credentials Committee and who make up the Alternate Committee member list:

REFERENCE COMMITTEE NUMBER 1—
Reports of Officers and Councilors
E. M. Howard, M.D., Harlan, Chairman
Rankin C. Blount, M.D., Lexington, Vice-Chairman
A. O. Miller, M.D., Louisville
J. L. Tanner, M.D., Henderson
H. E. Martin, M.D., Ashland

REFERENCE COMMITTEE NUMBER 2—
Reports on Medical Care, Medical Education, Hospitals and Related Subjects
Richard G. Elliott, M.D., Lexington, Chairman
Chris Jackson, M.D., Danville, Vice-Chairman
John D. Handley, M.D., Hodgenville
Clifton Follis, M.D., Glasgow
Marc Reardon, M.D., Covington

REFERENCE COMMITTEE NUMBER 3—
Reports on Legislation and Public Relations
Charles Maguire, M.D., Louisville, Chairman
Carl Fortune, M.D., Lexington, Vice-Chairman
Donald L. Graves, M.D., Frenchburg
Ralph D. Lynn, M.D., Elkton
Norman Adair, M.D., Covington

REFERENCE COMMITTEE NUMBER 4—
Reports on Miscellaneous Business
T. O. Meredith, M.D., Harrodsburg, Chairman
W. E. Becknell, M.D., Manchester, Vice-Chairman
F. P. Giannini, M.D., Princeton
Robert S. Dyer, M.D., Louisville
T. R. Davies, M.D., Barbourville

REFERENCE COMMITTEE NUMBER 5—
Reports on Miscellaneous Business
Roy H. Moore, Jr., M.D., Louisville, Chairman
Frank Duncan, M.D., Monticello, Vice-Chairman
Glenn W. Bryant, M.D., Louisville
A. D. Butterworth, M.D., Murray
Charles F. Martin, M.D., Winchester

REFERENCE COMMITTEE NUMBER 6—
Reports on Miscellaneous Business
Leon Higdon, M.D., Paducah, Chairman
Carl Pigman, M.D., Whitesburg, Vice-Chairman
Blaine Lewis, Jr., M.D., Louisville
Douglas Jenkins, M.D., Richmond
W. G. Eads, M.D., Calhoun

REFERENCE COMMITTEE NUMBER 7—
Reports on Miscellaneous Business
L. F. Beasley, M.D., Franklin, Chairman
Keith P. Smith, M.D., Corbin, Vice-Chairman
Carl Cooper, Jr., M.D., Bedford
Charles C. Rutledge, M.D., Hazard
J. A. Llewellyn, M.D., Louisville

CREDENTIALS COMMITTEE
Charles R. Yancey, M.D., Hopkinsville, Chairman
Glenn Marcum, M.D., Irvine
E. A. Barnes, M.D., Albany

ALTERNATE COMMITTEE MEMBERS
H. G. Sargent, M.D., Barlow
J. P. Wyles, M.D., Cynthiana
Ward Bushart, M.D., Fulton
J. S. Williams, M.D., Nicholasville
W. P. McKee, M.D., Eminence
Robert Hoffman, M.D., South Fort Mitchell
John Allen, Jr., M.D., Louisville
Carl Kumpe, M.D., Fort Mitchell
S. E. Farmer, M.D., Brownsville
David Asher, M.D., Pineville
J. W. Miller, M.D., Greensburg
D. G. Miller, M.D., Morgantown.

Nominating Committee to Hold First Session September 17

Any KSMA member wishing to confer with the Nominating Committee for General KSMA Officers for the 1956-57 year will have the opportunity to do so immediately following the close of the first session of the House of Delegates at the Columbia Auditorium, Monday evening, September 17, according to Howell J. Davis, M.D., Owensboro, chairman of the committee.

Procedures for the operation of the committee as set forth by the By-laws adopted at the 1955 session will be carefully followed, Dr. Davis said. The Speaker of the House will announce at the close of the first meeting the location of the second session the Nominating Committee will hold. Dr. Davis urged all members interested in the work of this committee to appear at that time.

Recommendations of the nominating committee will be presented at 1:45 PM, Tuesday in the Auditorium just prior to the beginning of the second scientific session, as called for in the By-laws. At this time the nominee or nominees for each office will be announced.

General election of officers will be held on Wednesday evening, September 19 near the close of the final session of the House. The recommendations of the Nominating Committee will again be read. By-laws provide that other nominations may be made from the floor "without discussion or comment."

Other members of the Nominating Committee are: W. B. Atkinson, M.D., Campbellsville; Thomas J. Gilbert, M.D., Bowling Green; John Harter, M.D., Louisville and Harvey Stone, M.D., Hopkinsville.

Five KSMA District Councilors to be Elected September 19

Five KSMA councilors will be elected for three year terms at the final session of the House of Delegates, Wednesday September 19 at Columbia Auditorium, according to J. Vernon Pace, M.D., Paducah, chairman of the Council.

Councilors will be elected for the following districts: first, third, fourth, twelfth and fourteenth.

Incumbent councilors are: J. Vernon Pace, M.D., Paducah; Delmas Clardy, M.D., Hopkinsville; W. Keith Crume, M.D., Bardstown; Garnett Sweeney, M.D., Liberty and John Archer, M.D., Prestonsburg. All are eligible to succeed themselves except Dr. Clardy.

The method of selecting nominees for the office of district councilor as set forth in the By-laws is:

"The Delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating Councilor for the Councilor District concerned. This committee shall hold a meeting open to all active members of Councilor District concerned who are in attendance at the meeting for the purpose of discussing the nomination for the Councilor to serve the District. Additional nominations may be made from the floor by any member of the House of Delegates when the Nominating Committee makes its report to the House of Delegates."

The Speaker of the House will announce, at the close of the first session of the House, the location of the meetings for the delegates of each district who will nominate a councilor.

Awards Committee to Follow New Procedure at '56 Meet

The 1956 winners of the Distinguished Service Medal and the Outstanding General Practitioner Award, named each year by the House of Delegates, will be selected by a new procedure as a result of action at the 1955 meeting of the House.

The Awards Committee, of which Ernest Strode, M.D., Lexington, is chairman, has functioned throughout the year following its appointment by the speaker of the House at the close of the 1955 meeting.

The new procedure calls for Dr. Strode's committee to report its nominations for the two high honors at the first meeting of the House, on Monday evening Sepember 17. At the second meeting on Wednesday evening, before the House votes on these nominees, additional nominations may be made from the floor.

Last year the Distinguished Service Medal went to J. B. Lukins, M.D., Louisville and A. O. Miller, M.D., Scottsville, was presented the General Practitioner Award.

Other members of the Awards Committee are: Hugh Adkins, M.D., Louisville; Joseph Kurre, M.D., Owensboro; Frank Sewall, M.D., Mt. Sterling; and Charles Yancey, M.D., Hopkinsville.

Record Number of Exhibitors to Participate in Meeting

Benefits, both practical and positive, will be received by all who visit the booths in the Technical Exhibit Hall at the 1956 Annual Meeting, W. O. Johnson, M.D., chairman of the Committee on Technical Exhibits, promised.

A record number of 65 spaces have been purchased by companies that are working together to meet today's exacting requirements of medicine and surgery, Dr. Johnson stated.

"The 1956 KSMA Technical Exposition stands out as an important educational feature of this meeting—and encyclopedia of new ideas, new services, new techniques and authoritative information about the products with which we work", Dr. Johnson said.

The exposition officially opens at 8 AM (CDST), Tuesday morning, September 18. It will open each morning at 8 and close at 5:30 except on Thursday, when it will close for the meeting at 3:30 PM. The program committee has scheduled time for all attending the meeting to visit the exhibits at regularly scheduled intermissions both during the morning and afternoon sessions, as well as between and after sessions.

Dr. Johnson pointed out that each exhibiting company was carefully screened and only companies with approved products accepted.

A new three-cent commemorative US postage stamp, honoring the fiftieth anniversary of the passage of the first Federal Food and Drug Act, was issued June 27. The stamp is dedicated to Dr. Harvey W. Wiley, the chemist who was a major force behind the passage of the act.

Guest Speakers

EDGAR BURNS, M.D.*
New Orleans, Louisiana

Dr. Burns, director of the department of urology at the Ochsner Clinic and Foundatiin Hospital in New Orleans, is president of the American Board of Urology.



A graduate of Northwestern University Medical School, he is professor and chairman of the Department of Urology at Tulane University Medical School.

Dr. Burns is a member of the Southern Surgical Association, the American College of Surgeons, the American Association of Genito-Urinary Surgeons and the American Urological Association.

On Thursday September 20 at 2 PM Dr. Burns will talk on "Management of Urinary Tract Infections." His talk before the specialty group session Wednesday afternoon will be entitled "Injuries of the Urinary Tract During General and Gynecologic Surgery."

FRANZ REICHSMAN, M.D.*
Rochester, New York

Dr. Reichsman, a native of Vienna, Austria, is assistant professor of psychiatry and medicine at the University of Rochester. He received his MD in 1938 from the University of Vienna.



Dr. Reichsman, who became an American citizen in 1947, was research assistant in the department of medicine at Johns Hopkins Medical School from 1939-40; assistant professor of medicine at Southwestern Medical College in Dallas from June 1944 to December 1945 and Commonwealth Fund Fellow in Psychiatry and Medicine at Rochester University from 1952 to 1954.

He is a member of the American Psychosomatic Society, American Psychiatric Association (associate) and the New York Academy of Sciences.

He will discuss "Behavior and Gastric Secretion: A Study of an Infant with a Gastric Fistula" before the general assembly at 1:50 PM, Tuesday, September 18, and "Spontaneous and Experimentally Induced Depressions in an Infant with a Gastric Fistula" at the specialty group session.

PAUL T. CHAPMAN, M.D.*
Detroit, Michigan

Dr. Chapman, tuberculosis controller for the City of Detroit since 1951, is the author of a number of papers on the treatment and control of tuberculosis. He is a graduate of the University of Cincinnati Medical School.



Since completion of a residency in thoracic surgery in 1939 he has served as chief physician and later as chief of tuberculosis hospitalization and field service for the City of Detroit.

Dr. Chapman is assistant clinical professor at Wayne University; instructor in the School of Public Health at the University of Michigan; special consultant of the United States Public Health Service and senior consultant in TB at the Veterans Administration Hospital in Dearborn.

He will discuss "Present Status of Chemotherapy for Tuberculosis" before the general assembly, at 4 PM Tuesday, September 18. Before the specialty group session on Wednesday the 19th, Dr. Chapman will speak on "Hospital and Post Sanatorium Treatment of Tuberculosis in Detroit."

Indicates that the speaker in addition to addressing one of the General Scientific Sessions of the KSMA Annual Meeting is also scheduled to speak before one of the Specialty groups on Wednesday afternoon.

FRANK L. McPHAIL, M.D.*
Great Falls, Montana

Dr. McPhail, past president of the Montana Medical Association, is the senior obstetrician and gynecologist at the Great Falls Clinic and obstetrician and gynecologist at the Montana Deaconess Hospital.



A graduate of the University of Michigan Medical School, he was certified by the American Board of Obstetrics and Gynecology in 1937.

Dr. McPhail is a member of the American Association of Obstetricians and Gynecologists, the American Academy of Obstetrics and Gynecology and a Fellow of the American College of Surgeons. He is past president of the Pacific Northwest Obstetrical and Gynecological Association and of the Central Association of Obstetricians and Gynecologists and is chairman of the Western Interstate Commission on Higher Education.

Dr. McPhail's talk before the general assembly Thursday, September 20 will be entitled "Early Diagnosis of Carcinoma of the Cervix" and before the specialty group session, "Pelvic Endometriosis."

JOSEPH R. BUSTETTER, D.D.S.
Louisville

Dr. Bustetter, Louisville, nationally recognized in the field of prosthetics, will be the guest scientific speaker from the Dental profession at the 1956 Annual Meeting. He is past president of the Kentucky Section of the American College of Dentists.



Born in Greenup, Kentucky, April 28, 1906, Dr. Bustetter was graduated from the Universty of Louisville School of Dentistry in 1930. Since graduation he has been a member of the faculty.

A past president of the Louisville District Dental Society and consultant in Prosthetic Dentistry to the Veterans Administration, Dr. Bustetter is a member of the ADA, the American Association for Cleft Palate Rehabilitation and the American College of Dentists.

He will speak September 18 at 2:30 PM on "The Prosthetic Management of Palatal Deficiencies, Congenital and Acquired."

LOUIS A. BUIE, M.D.
Rochester, Minnesota

Dr. Buie, professor emeritus of proctology at the Mayo Foundation Graduate School, University of Minnesota, is also an emeritus member of the Mayo Clinic.



A graduate of the University of Maryland School of Medicine, Dr. Buie has been certified by the American Boards of Surgery and Proctology.

Dr. Buie, a member of the AMA Judicial Council, is chairman of the Council on Constitution and By-laws. He is vice chairman of the General Advisory Committee of the National Foundation for Infantile Paralysis.

He will discuss "Office Practice in Proctology" at the specialty group session Wednesday afternoon, September 19.

WENDELL G. SCOTT, M.D.*
St. Louis, Missouri

Dr. Scott, a graduate of Washington University School of Medicine in St. Louis, is associate professor of clinical radiology at the school.



Chairman of the Commission on Public Relations of the American College of Radiology, Dr. Scott is associate editor of the American Journal of Roentgenology, Radium Therapy and Nuclear Medicine.

Dr. Scott is also consultant to the Veterans Administration and

the Department of the Navy and chairman of the Special Medical Advisory Group Department of Medicine and Surgery of the Veterans Administration in Washington, D. C.

Dr. Scott will discuss "Carcinoma of the Colon and Its Early Detection" at 3:30 PM, September 18. He will speak on "The Use of Radioactive Isotopes in the Treatment of Cancer" before the specialty group session September 19.

KATHARINE DODD, M.D.*
Little Rock, Arkansas

Dr. Dodd, a native of Providence, Rhode Island, attended Bryn Mawr College and was graduated from The Johns Hopkins Medical School in 1921. She served residencies in pediatrics at Hopkins and Yale.



She began her medical career with the Quakers and in 1925 went to Vanderbilt as assistant and later associate professor of pediatrics. From 1944 to 1952 she was associate professor of pediatrics and research fellow of the Children's Hospital Research Foundation in Cincinnati. She is now professor of pediatrics and head of the Department at the University of Arkansas School of Medicine.

"Salicylate Poisoning" will be the subject for discussion by Dr. Dodd at the general session September 18. She will discuss "Anaphylactoid Purpura" at the specialty group session.

Dr. Dodd will give a third talk at the specialty group session on Wednesday, September 19. She will speak on "Diabetes Mellitus in Childhood."

KSMA members are urged by the Committee on Arrangements to purchase tickets for the President's Luncheon, Wednesday, September 19 at the registration desk at the Auditorium. The same system of reserving seats that has worked successfully for the last two years will be employed at the 1956 session.

J. OTTO LOTTES, M.D.*
St. Louis, Missouri

Dr. Lottes, clinical instructor in orthopedic surgery at Washington University School of Medicine, received a PhG degree from the St. Louis College of Pharmacy and his MD from the University of Louisville. He took his orthopedic surgery training at St. Louis City Hospital, Barnes Hospital and Washington University.



A diplomate of the American Board of Orthopedic Surgery and the American College of Surgeons, Dr. Lottes is section chief of orthopedic surgery at St. Anthony's Hospital and the St. Louis City Hospital.

He is a member of the AMA, SMA, St. Louis Orthopedic Society and the American Academy of Orthopedic Surgeons.

Dr. Lottes, who is in charge of the US Army research of Intramedullary Nailing of the Tibia, will talk on "Complications and Errors in the Treatment of Fractures of the Tibia With the Lottes Nail" at the specialty group session on Wednesday September 19. He will discuss "Treatment of Fractures in Children", Wednesday, September 19 at 11 AM.

JOHN E. BORDLEY, M.D.*
Baltimore, Maryland

Dr. Bordley, a 1929 graduate of The Johns Hopkins University School of Medicine, is now otolaryngologist-in-charge at the Hopkins Hospital and professor and director of the Department of Laryngology and Otology at the school.



Other appointments include visiting otolaryngologist at Prince Alfred Hospital in Sydney, Australia; chief consultant at Baltimore City Hospital; regional consultant in audiology for the Veterans Administration; and faculty member of

The International Course in Audiology.

Dr. Bordley, who served in the US Army Medical Corps, is a diplomate of the American Board of Otolaryngology, a member of the American Laryngological Association, American Otological Society and the National Board of Medical Examiners.

Topics Dr. Bordley will discuss are "Clinical Evaluation of the Rhinotomy Operation" at the general session on Wednesday, September 19 and "The Diagnosis of Central Nervous Pathway Hearing Impairment" at the specialty group session.

C. RONALD STEPHEN, M.D.*
Durham, North Carolina

Dr. Stephen, a 1940 graduate of McGill University has been consultant in anesthesia at the Veterans Administration Hospital in Durham since 1953.



In 1946 and 47 he was director of anesthesia at the Neurological Institute in Montreal. From 1947 to 1950 he was director of the department of anesthesiology at Children's Memorial Hospital in Montreal.

A member of the American Society of Anesthesiologists, Dr. Stephen is professor of anesthesia and chief of the division of anesthesia at Duke Hospital and University School of Medicine. From 1948 to 1950 he was assistant professor of anesthesia at McGill University.

Dr. Stephen will speak on "Ventilation in Anesthesia" at the specialty group session Wednesday, September 19. He'll discuss "Pitfalls in Pediatric Anesthesia" at the general assembly, Thursday, September 20, at 2:30 PM.

The Committee on Arrangements urges that K.S.M.A. membe:s wear their badges at all times while attending the Annual Meeting Sessions at Columbia Auditorium, September 18, 19 and 20.

I. FRANK TULLIS, M.D.*
Memphis, Tennessee

Dr. Tullis is professor of medicine and chief of the division of medicine at the University of Tennessee School of Medicine. He is a graduate of the school.



Dr. Tullis interned and served a residency at John Gaston Hospital in Memphis. He served in the army as chief of the field party of the Institute of Inter - American Affairs in Honduras, Central America.

He is a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians.

"Isotropylnoretinethrine in Complete Heart Block" will be the title of Dr. Tullis' specialty group speech on Wednesday afternoon, September 19. He will discuss "The Problem of Arrhythmias in Cardiac Emergencies", at 10:45 AM Tuesday, September 18 before the General Assembly.

William McGrath to Speak at President's Luncheon

William L. McGrath, Cincinnati, employer's delegate to the International Labor Organization, will be the guest speaker at the annual President's Luncheon Wednesday September 19 at 12:00 on the Roof Garden at the Brown Hotel.



The Rt. Rev. C. Gresham, Louisville, of Christ Church Cathedral, will give the invocation. Gant Gaither, M.D., Hopkinsivlle, KSMA president, will preside at the luncheon. Dr. Gaither will recognize past presidents of the KSMA and presidents of the Council on Allied Medical Service.

Mr. McGrath, who will be remembered for his dynamic talk at the 1956 County Society Officers Conference in Lexington, will speak on "Life Among the World Planners."

Mr. McGrath, president of a Cincinnati heating company, is director of a trust company, gas and electric company, Cincinnati Enquirer and the National Association of Manufacturers.

He is past president of the Cincinnati Chamber of Commerce and the National Society for the Advancement of Manufacturers.

11 Specialty Groups to Meet at 1956 Annual Meeting

Two more groups have joined the specialty group rank bringing the '56 Annual Meeting number to 11, according to KSMA president, Gant Gaither, M.D. The two new ones are the Kentucky Radiological Society and the Kentucky Orthopedic Society.

Each of these 11 groups will sponsor an afternoon long scientific program on Wednesday afternoon, September 19.

KSMA members are free to attend any of the meetings which will run simultaneously.

Talks by nationally recognized physicians and top flight Kentucky men and round table discussions will be presented at these sessions according to Dr. Gaither.

Dr. Gaither pointed out that the general assembly will be teamed primarily to the general practitioner. "These specialty group sessions are more technical and are aimed at the men who limit their practice. These sessions will offer an opportunity for them to get the latest knowledge on happenings in their particular fields."

Other specialty groups besides the two already mentioned are: Kentucky Society of Anesthesiologists; Kentucky Chapter, American College of Chest Physicians; Kentucky Eye, Ear, Nose and Throat Society; Kentucky Academy of General Practice; Kentucky Obstetrical and Gynecologic Society; Kentucky Chapter, American Academy of Pediatrics; Kentucky Chapter, American College of Physicians; Kentucky Psychiatric Association and the Surgical Congress.

GP's Will Receive Credit

The entire scientific program of the 1956 Annual Meeting of the Kentucky State Medical Association will be recognized for credit by members of the Kentucky Academy of General Practice. All programs will be accepted for credit under category II. It is expected by competent observers that those who sign up for either of the three two-hour post-graduate refresher courses and those who attend the Wednesday afternoon program of the Kentucky Academy of General Practice will receive credit under category I.

OFFICIAL CALL
ANNUAL MEETING
KENTUCKY STATE MEDICAL ASSOCIATION

To the officers and members of the component county societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the KSMA will convene at the Columbia Auditorium, Louisville, Tuesday, Wednesday and Thursday, September 18, 19, and 20, 1956. The General Session will be called to order at 10:30 AM Tuesday. Three refresher courses and scientific movies start at 8 AM.

The House of Delegates

The first regular session of the House of Delegates will convene at 7:00 PM, Monday, September 17; the second regular session will begin at 7:00 PM, Wednesday, September 19. Both sessions will be held in the Columbia Auditorium.

Registration

The registration department will be open in the Columbia Auditorium from 6:00 PM to 8:00 PM Monday, September 17 from 7:45 AM to 5:00 PM on Tuesday, September 18; from 7:45 AM to 5:00 PM and 6:00 PM to 8:00 PM on Wednesday, September 19, and from 7:45 AM to 5:00 PM on Thursday, September 20.

WOMAN'S AUXILIARY
to the
KENTUCKY STATE MEDICAL ASSOCIATION

Tuesday, September 18, Brown Hotel
Pre-convention Board Breakfast, 9 AM, Parlors A, B, C, Brown Hotel; Formal opening of the thirty-fourth Annual Meeting, 10:30 AM, South Room.

Wednesday, September 19, Brown Hotel
Morning session, 9 AM, South Room; Afternoon session, beginning with a subscription luncheon; Style show at 1 PM in the Ball Room.

Thursday, September 20, Brown Hotel
Post-convention Board Breakfast (subscription) and meeting, 9 AM, South Room.

Registration

The registration department of the Woman's Auxiliary will be open in the North Bay of the lobby of the Brown Hotel on Monday, September 17 from 12 noon to 5 PM; Tuesday, September 18, 9 AM to 5 PM and Wednesday, September 19, 9 AM to 11 AM.

Post-graduate Refresher Courses Innovation at '56 Meeting

A bold new carefully planned program, designed especially for the top level general practitioner, will be presented from 8 to 10 o'clock Central Daylight Time each morning during the Annual Meeting.

There will be three of these courses staged simultaneously, with attendance limited to 50 in each course, according to Rudolf Noer, M.D., Louisville, of the KSMA Committee on Scientific Assembly, who is chairman of the subcommittee on Post Graduate Refresher Courses for the 1956 session.

"The Management of Trauma", "Common Problems in Infants and Children" and "A Medical Symposium" are the titles of the three courses. These programs will include discussions of the latest procedures and drugs, and will be given by top-flight faculty members of the University of Louisville School of Medicine.

The Management of Trauma course will be under the direction of Harold E. Kleinert, M.D., Louisville, and will be held in the old ballroom at the Columbia Auditorium. The Tuesday program will center around the general considerations in the management of injured patients. Special considerations will be given to anesthesia for the injured patient and to recent developments in attempts at prevention of automobile produced injuries.

Problems on the multiple injury patient will be discussed on Wednesday. Special consideration will be given to the emergency treatment of fractures and to transportation of the injured patient, particularly those with fractures.

Thursday's program will feature special problems in trauma. This will include a motion picture demonstration of thoracic injuries, the use of tracheostomy in badly injured patients, cranial trauma, the emergency treatment of burns and the emergency care of eye injuries. This final session will end with a question and answer period in which all participants in the course will be available for a round table discussion of the material covered.

"Common Problems of Infants and Children" will be presented under the leadership of Alex J. Steigman, M.D., and Joseph Little, M.D., Louisville. The pediatrics group will meet in the Louis XVI Room of the Brown Hotel.

Dr. Steigman will preside at the Tuesday session and Dr. Little at the Thursday meeting. W. A. Brodsky, M.D., Louisville, will act as presiding officer at the Wednesday refresher course.

The first course on Tuesday will concern the various causes of diarrhea in infants and children and the means for diagnosis and treatment. Wednesday's program will present the anemias of childhood. Discussions on infectious disease of childhood will be presented at the final session on Thursday.

"Medical Symposium" will be under the supervision of the new chairman of the University of Louisville School of Medicine, Beverly Todd Towery, M.D. This course will be held in the lounge on the lower level at the Columbia Auditorium.

J. Murray Kinsman, M.D., dean of the medical school, will preside over the first course on Tuesday. This discussion will center around a consideration of the recognition and management of the common causes of coma.

Dr. Towery will preside over the Wednesday and Thursday sessions. Attendants at the Wednesday session will hear discussed the problems encountered in the care of the desperately ill patient. Thursday's session will be entitled "Recent Progress in the Recognition and Treatment of Thyroid Disorders."

A small registration fee of $5.00 to cover costs of this and future courses will be charged, according to Dr. Noer. No fee is being paid physicians giving the programs. Since attendance is limited, Dr. Noer urged that the coupon provided below be clipped and returned at your earliest convenience together with your check in order that you may be insured a place at the course.

Full details on the refresher courses were not available at press time. A complete program will be mailed to each KSMA member at a later date.

COMMITTEE ON POST GRADUATE REFRESHER COURSES
620 South Third Street
Louisville 2, Kentucky

Pleose enroll me in

_____
(subject of course you desire)

Which will be held from 8 to 10 AM September 18-20

I enclose o check for $_____to cover cost of course.

_____ M.D.

_____
Town County

Kentucky Urologists to Meet

The Kentucky Urologists will hold their regular quarterly meeting in Louisville, Tuesday, September 18 at the Pendennis Club.

The meeting, which will be held during the KSMA Annual Meeting, will begin at 6 PM with cocktails and dinner. A pyelogram clinic will follow. Reservations can be made by writing John Robbins, M.D., 1423 Heyburn Building, Louisville.

ANNUAL MEETING PROGRAM SUMMARY

THE KENTUCKY STATE MEDICAL ASSOCIATION

SEPTEMBER 17, 18, 19, 20, 1956

LOUISVILLE

MONDAY, SEPTEMBER 17

2:00 A. M.	Council Meeting	Louis XVI Room, Brown Hotel
5:00 P. M.	Council Dinner	Louis XVI Room, Brown Hotel
6:00 P. M.	Registration of House of Delegates	Columbia Auditorium
7:00 P. M.	First Meeting of House of Delegates	Columbia Auditorium

TUESDAY, SEPTEMBER 18

7:45 A. M.	Registration	Columbia Auditorium
8:00 A. M.	Refresher Courses and Scientific Movies	Columbia Auditorium & Brown Hotel
10:30 A. M.	Opening Ceremonies	Columbia Auditorium
10:45 A. M.	First Scientific Session	Columbia Auditorium
11:45 A. M.	President's Address	Columbia Auditorium
1:45 P. M.	Second Scientific Session	Columbia Auditorium
2:00 P. M.	Reference Committee Meetings	Columbia Auditorium

WEDNESDAY, SEPTEMBER 19

8:00 A. M.	Refresher Courses and Scientific Movies	Columbia Auditorium, Brown Hotel
10:30 A. M.	Third Scientific Session	Columbia Auditorium
11:50 A. M.	President's Luncheon for Distinguished Guests	Roof Garden, Brown Hotel
1:45 P. M.	Specialty Group Sessions (Replacing the regular general session will be 11 specialty group scientific programs, which will be held simultaneously. Any KSMA member may attend any or as many of these meetings as desired.)	
5:00 P. M.	Council Dinner	Louis XVI Room, Brown Hotel
6:00 P. M.	Registration, House of Delegates	Columbia Auditorium
7:00 P. M.	Second Meeting, House of Delegates	Columbia Auditorium

THURSDAY, SEPTEMBER 20

8:00 A. M.	Refresher Courses and Scientific Movies	Columbia Auditorium & Brown Hotel
10:30 A. M.	Fourth Scientific Session	Columbia Auditorium
11:30 A. M.	Inaugural Ceremony, Presentation of Awards	Columbia Auditorium
12:15 P. M.	Council Luncheon	Parlors A,B,C, Brown Hotel
2:00 P. M.	Fifth Scientific Session	Columbia Auditorium
4:30 P. M.	Adjournment	

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting the Scientific and Technical Exhibits.

SCIENTIFIC PROGRAM

* * *

THE J. A. HODGE MEMORIAL MEETING

COLUMBIA AUDITORIUM

* * *

THE KENTUCKY STATE MEDICAL ASSOCIATION

Tuesday, September 18
COLUMBIA AUDITORIUM

7:45 Registration
8:00 **Refresher Courses and Scientific Movies***
10:00 **Visit Exhibits**
10:30 Opening of General Session
Call to Order by the President
Gant Gaither, M.D., Hopkinsville
Invocation
Rev. Brent Wood, Louisville Pastor, Strathmoor Presbyterian Church
Welcoming Remarks
Irvin Abell, Jr., M.D., Louisville, President Jefferson County Medical Society
Announcements
Richard R. Slucher, M.D., Louisville, KSMA President-elect

FIRST SCIENTIFIC SESSION

Gant Gaither, M.D., Hopkinsville, KSMA President, Presiding

10:45 **"The Problem of Arrhythmias in Cardiac Emergencies"**
I. Frank Tullis, M.D., Memphis, Tennessee
11:15 **"Salicylate Poisoning"**
Katharine Dodd, M.D., Little Rock, Arkansas
11:45 President's Address
Lunch

SECOND SCIENTIFIC SESSION

Everett Baker, M.D., Louisville, Vice president (Central), Presiding

1:45 Report of Nominating Committee
1:50 **"Behavior and Gastric Secretion: A Study of an Infant with a Gastric Fistula"**
Franz Reichsman, M.D., Rochester, New York
2:30 **"The Prosthetic Management of Palatal Deficiencies, Congenital and Acquired"**
Joseph R. Bustetter, D.D.S., Louisville
3:00 **Visit Exhibits**
3:30 **"Carcinoma of the Colon and its Early Detection"**
Wendell G. Scott, M.D., St. Louis, Missouri
4:00 **"Present Status of Chemotherapy for Tuberculosis"**
Paul T. Chapman, M.D., Detroit, Michigan

Wednesday, September 19
THIRD SCIENTIFIC SESSION

8:00 **Refresher Courses and Scientific Movies***
10:00 **Visit Exhibits**
10:30 **"Clinical Evaluation of the Rhinotomy Operation"**
John E. Bordley, M.D., Baltimore, Maryland
11:00 **"Treatment of Fractures in Children"**
J. Otto Lottes, M.D., St. Louis, Missouri

For more information see story on pages 693, 701.

PRESIDENT'S LUNCHEON
ROOF GARDEN—BROWN HOTEL
Wednesday, September 19
11:50 A. M.

Gant Gaither, M.D., Hopkinsville, President, Presiding

Invocation
Rt. Rev. C. Gresham Marmion, Louisville, Bishop of the Episcopal Diocese of Kentucky
Recognitions
Gant Gaither, M.D.
"Life Among the World Planners"
William L. McGrath, Cincinnati
Employer's Delegate to the International Labor Organization, Geneva

Explanation of Wednesday Afternoon Program

Eleven specialty groups will present scientific programs simultaneously Wednesday afternoon and there will be no general session. The programs will be held in the Columbia Auditorium, The First Christian Church, and the Calvary Episcopal Church. These eleven group meetings will get under way at 1:45 P.M. At 2:45 a 45 minute intermission to visit the exhibits has been scheduled. At 3:30 the eleven groups will again go into session for the final portion of their programs. KSMA members are free to move from one group to another during these sessions.

Kentucky Society of Anesthesiology

1:45 **"Convulsion During Anesthesia"**
Robert P. Bergner, M.D., Louisville
2:15 **"Anesthesia for Thoracic Surgery"**
Walden R. Smith, M.D., Louisville
2:45 **Visit Exhibits**
3:30 **"Clinical Experience with Use of Phenergan in Prevention of Post-operative Nausea and Vomiting"**
German P. Dillon, Jr., M.D., Louisville
4:00 **"Ventilation in Anesthesia"**
C. R. Stephen, M.D., Durham, North Carolina

Kentucky Chapter—American College of Chest Physicians

1:45 **"Spontaneous Pneumothorax, Results of Pulmonary Resection"**
Porter Mayo, M.D., Lexington
2:15 **"Hospital and Post-Sanatorium Treatment of Tuberculosis in Detroit"**
Paul T. Chapman, M.D., Detroit, Michigan
2:45 **Visit Exhibits**
3:30 **"Pleurisy with Effusion"**
Daniel N. Pickar, M.D., Louisville
4:00 **"Clinical Application of Pulmonary Function Studies"**
Grover B. Sanders, M.D., Louisville

Kentucky Eye, Ear, Nose and Throat Society

1:45 "Intermittent Exotropia"
Francis Heed Adler, M.D., Philadelphia, Pennsylvania

2:15 "Role of the Boney Orbital Angles in Horizontal Strabysmus"
Hoda Zaki, M.D., Louisville
A. Keeney, M.D., Louisville

2:45 Visit Exhibits

3:30 "Diagnosis of Central Nervous Pathway Hearing Impairment"
John E. Bordley, M.D., Baltimore, Maryland

4:00 "Clinical Otosclerosis-Fenestration or Stapes Mobilization"
Arthur Juers, M.D., Louisville

Kentucky Academy of General Practice

1:45 "Antibiotic Therapy"
Edward L. Quinn, M.D., Detroit, Michigan

2:15 "Arterial Hypertension"
Hunt Jones, M.D., Louisville

2:45 Visit Exhibits

3:30 "Office Practice in Proctology"
Louis A. Buie, M.D., Rochester, Minnesota

4:00 "The Mechanism and Management of Breech Presentation"
Frank E. Whiteacre, M.D., Nashville, Tennessee

Kentucky Obstetrical and Gynecologic Society

1:45 "Complications of the Puerperium"
Douglas Haynes, M.D., Louisville

2:15 "Endometriosis"
Frank McPhail, M.D., Great Falls, Montana

2:45 Visit Exhibits

3:30 "Obstetrical Difficulties (Round Table)
Frank McPhail, M.D.
Silas Starr, M.D., Louisville
Douglas Haynes, M.D.
Ed Masters, M.D., Louisville (moderator)

Kentucky Orthopedic Society

1:45 "Surgical Treatment of Torticollis in Infants"
Daniel Costigan, M.D., Louisville
James Riley, Jr., M.D., Louisville

2:15 "Ligamentous Injuries to the Cervical Spine"
Armand Fischer, M.D., Louisville
Kenton Leatherman, M.D., Louisville

2:45 Visit Exhibits

3:30 "Complications and Errors in Treatment of Fractures of the Tibia With the Lottes Nail"
J. Otto Lottes, M.D., St. Louis, Missouri

4:00 "Functional Fixation of Intracapsular Fractures of the Neck of the Femur"
William Massie, M.D., Lexington

Kentucky Chapter, American Academy of Pediatrics

1:45 "Anaphylactoid Purpura"
Katharine Dodd, M.D., Little Rock, Arkansas

2:45 Visit Exhibits

3:30 "Diabetes Mellitus in Childhood"
Katharine Dodd, M.D.

Kentucky Chapter, American College of Physicians

1:45 "Ovarian Agenesis"
Thornton Scott, M.D., Lexington

2:15 "Isotropylnoretinethrine in Complete Heart Block"
I. Frank Tullis, M.D., Memphis, Tennessee

2:45 Visit Exhibits

3:30 "Roentgenology in Internal Medicine"
Sidney E. Johnson, M.D., Louisville

4:00 "Blood Dyscrasia Following Drug Therapy"
Murray L. Rich, M.D., Covington

*For more information see story on pages 693, 701.

Kentucky Psychiatric Association

1:45 "Review of Commitment Procedures"
Frank M. Gaines, M.D., Louisville

2:15 "Report on Blue Cross-Blue Shield Investigation"
Louis Foltz, M.D., Louisville

2:45 Visit Exhibits

3:30 "Spontaneous and Experimentally Induced Depressions in an Infant with Gastric Fistula"
Franz Reichsman, M.D., Rochester, New York

4:00 Formal Discussions
H. Halbert Leet, M.D., Lexington
Abraham Wikler, M.D., Lexington

Kentucky Radiological Society

1:45 "Roentgen Differentiation of Ante Lung Diseases"
Everett L. Pirkey, M.D., Louisville

2:15 "The Use of Radioactive Isotopes in the Treatment of Cancer"
Wendell G. Scott, M.D., St. Louis, Missouri

2:45 Visit Exhibits

3:30 "Lesions of the Small Bowel"
Norman Adair, M.D., Covington

4:00 "Roentgen Aspects of Blastomycosis"
Ralph Quillen, M.D., Lexington
LeRoy Boswell, M.D., Lexington

Kentucky Chapter, American College of Surgeons

1:45 "Problems of a Cancer Clinic in a Hundred Bed Hospital"
Henry S. Harris, M.D., Bowling Green

2:15 "A Follow Up on a Cholecystectomy Patient"
Marc Reardon, M.D., Covington

2:45 Visit Exhibits

3:30 Injuries of the Urinary Tract During General and Gynecologic Surgery"
Edgar Burns, M.D., New Orleans, Louisiana

4:00 "The Surgery of Peripheral Arteriosclerotic Occlusive Disease"
J. Herman Mahaffey, M.D., Louisville

Thursday, September 20
FOURTH SCIENTIFIC SESSION

Gant Gaither, M.D., President, Presiding

8:00 Refresher Courses and Scientific Movies*

10:00 Visit Exhibits

10:30 "A New Factor in Maternal Mortality"
Henry Turner, M.D., Memphis, Tennessee

11:00 "Early Diagnosis of Carcimona of the Cervix"
Frank L. McPhail, M.D., Great Falls, Montana

11:30 Presentation of Awards
Woodford B. Troutman, M.D., Louisville
Inaugural Ceremonies
J. Vernon Pace, M.D., Paducah, Chairman of the Council
Presentation of Past President's Key
Richard R. Slucher, M.D., Louisville
Lunch

FIFTH SCIENTIFIC SESSION

Howell J. Davis, M.D., Owensboro, Vice President (Western) Presiding

2:00 "Management of Urinary Tract Infections"
Edgar Burns, M.D., New Orleans, Louisiana

2:30 "Pitfalls in Pediatric Anesthesia"
C. R. Stephen, M.D., Durham, North Carolina

3:00 Visit Exhibits

3:30 Upper Gastrointestinal Bleeding (Panel Discussion)
Rudolf J. Noer, M.D., Louisville (Moderator)
Arthur Schoen, M.D., Louisville
Everett Pirkey, M. D., Louisville
R. Arnold Griswold, M.D., Louisville
Richard Gott, M.D., Louisville
William Christopherson, M.D., Louisville

4:30 Adjournment

THIRTY-FOURTH ANNUAL MEETING

of the

WOMAN'S AUXILIARY

to the

Kentucky State Medical Association

BROWN HOTEL

Louisville, Kentucky

September 18, 19, 20, 1956

REGISTRATION:
North Bay of Lobby, Brown Hotel
Monday—12 noon to 5 p.m.
Tuesday—9 a.m. to 5 p.m.
Wednesday—9 a.m. to 11 a.m.
Chairman of Registration
Mrs. Donald Chatham, Shelbyville
Chairman of Hospitality
Mrs. T. J. Overstreet, Lexington
Hospitality Room open
Tuesday—10 a.m. to 5 p.m.
Wednesday—9 a.m. to 1 p.m.

Tuesday, September 18
9:00 A. M.
Parlors A, B, C, Brown Hotel

Preconvention Board Breakfast (subscription). The Board consists of all general state officers, councilors, state committee chairmen, county auxiliary presidents and three immediate past presidents.

Tuesday, September 18
10:30 A. M.
South Room

Formal opening of the Thirty-Fourth Annual Meeting of the Woman's Auxiliary to the Kentucky State Medical Association.
Presiding .....Mrs. R. Ward Bushart
Fulton, President
Invocation .....Mrs. William H. Cartmell
Maysville, First Vice-President
Pledge of Allegiance to the Flag
Mrs. Karl D. Winter
Louisville, Immediate Past President
"I pledge allegiance to the flag of the United States of America and to the Republic for which it stands, one Nation, under God, indivisible, with Liberty and Justice for all."
Pledge of Loyalty .....Mrs. Karl D. Winter
"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."
Address of Welcome
Mrs. Marvin A. Lucas, Louisville
President Jefferson County Auxiliary
Response .....Mrs. Clyde C. Sparks
Ashland, Past President
In Memoriam .....Mrs. E. W. Jackson
Paducah, Editor of Blue Grass News
and Past President
Presentation of Convention Chairman
Mrs. Parnell Rollings
Louisville
Presentation of Distinguished Guests
Roll Call .....Mrs. J. O. Mattax
Carrollton, Secretary
Minutes of the Thirty-Third Annual Meeting
Mrs. J. O. Mattax
Report of the 1956 National Convention
Mrs. J. Andrew Bowen
Louisville, State Program Chairman
Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association
Mrs. Lanier Lukins
Louisville
REPORTS OF OFFICERS:
Treasurer .....Mrs. B. T. Harris
Lexington
President-Elect and Organization Chairman
Mrs. Charles B. Stacy
Pineville
President .....Mrs. R. Ward Bushart
Old Business
New Business
Report of Nominating Committee
Mrs. Karl D. Winter
Chairman
Election of Nominating Committee, 1956-57
Presentation of 1956-57 Budget
Mrs. J. Murray Kinsman
Chairman of Finance
Report of Registration .....Mrs. Donald Chatham
Reports of State Chairmen

12:30 P. M.
South Room—Subscription Luncheon

Informal Round Table Discussions on County Projects during Luncheon
Luncheon in Honor of
Mrs. Robert Flanders
Manchester, New Hampshire
President, Woman's Auxiliary to
the American Medical Association
Mrs. John J. O'Connell .....St. Louis, Missouri
President, Woman's Auxiliary to
the Southern Medical Association
Invocation .....Mrs. G. B. Froage
Paducah, Third Vice-President
Address .....Mrs. Robert Flanders
Address .....Mrs. John J. O'Connell

2:00 P. M.
South Room

Reports of County Auxiliary Presidents

3:30 P. M.
Louis XVI Room

Tea Honoring Distinguished Guests
McCracken County Auxiliary .....Hostesses
All Doctors' Wives Invited

ACHROMYCIN*

Tetracycline *Lederle*

ACHROMYCIN is unsurpassed in its range of effectiveness. Each successive month more physicians are confirming this fact for themselves in their own daily practice in the therapy of respiratory, genitourinary, dermatologic and other infections.

ACHROMYCIN can be of service to you because of these important advantages:

- true broad-spectrum action
- rapid diffusion and penetration
- prompt control of infection
- proved effective against a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa
- side effects, if any, usually minimal
- produced under exacting quality control in Lederle's *own* laboratories and offered *only* under the Lederle label
- a *complete line* of dosage forms

ACHROMYCIN SF

ACHROMYCIN Tetracycline with STRESS FORMULA VITAMINS for severe or prolonged illness. Attacks the infection—defends the patient—hastens normal recovery. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.



LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

Lederle

*REG. U. S. PAT. OFF.

PHOTO DATA: 8 X 10 GROVER VIEW CAMERA
100 SEC. AT F.22 EXISTING LIGHT

ACHROMYCIN

Wednesday, September 19
9:00 A. M.
South Room

Invocation .....Mrs. William C. Cloyd
Richmond, Fourth Vice-President
Roll Call .....Mrs. J. O. Mattax
Reading of the Minutes .....Mrs. J. O. Mattax
Announcements .....Mrs. Parnell Rollings
Convention Chairman
Report of Revisions Committee
Mrs. John Harter
Chairman
Address—"One Great Avenue for the Auxiliary"
Gant Gaither, M.D.
Hopkinsville, President, K.S.M.A.
Safety Panel .....Mrs. C. Melvin Bernhard
Louisville, Second Vice-President, Presiding
Speaker .....Arnold Griswold, M.D.
Louisville, Chairman, American College of Surgeons' Committee on Trauma
Moderator .....William K. Keller, M.D.
Professor of Psychiatry, University of Louisville School of Medicine
Panel Members:
Mrs. Thomas A. Ballatine
Louisville, President of Yellow Cab
Colonel Carl Heustis
Louisville, Chief of Police
Louis Foltz, M.D.
Psychiatrist, Louisville
Election of Officers
Presentation of Distinguished Guests
Installation of Officers .....Mrs. Robert Flanders
Inaugural Address .....Mrs. Charles B. Stacy
Announcement of Committee Chairmen
Mrs. Charles B. Stacy
Final Report of Registration
Mrs. Donald Chatham
Adjournment

Wednesday, September 19
1:00 P. M.
Subscription Luncheon and Style Show
In Honor Of

Mrs. Robert Flanders
Manchester, New Hampshire
President, Woman's Auxiliary to the American Medical Association
Mrs. John J. O'Connell .....St. Louis, Missouri
President, Woman's Auxiliary to the Southern Medical Association
Mrs. Clark Bailey .....Harlan, Kentucky
Second Vice-President, Woman's Auxiliary to the A. M. A. and Past President of the Woman's Auxiliary to the K.S.M.A.
Past Presidents of the Woman's Auxiliary to the Kentucky State Medical Association
Invocation .....Mrs. Clark Bailey
Presentation of Distinguished Guests
Presentation of Past Presidents
Presentation of Officers
Presentation of Health Citation Award
Mrs. Earl W. Roles
Louisville, Chairman Award Committee of Woman's Auxiliary to K.S.M.A.
Style Show .....Ball Room

Thursday, September 20
9:00 A. M.
South Room

Post-Convention Board Breakfast (subscription) and Meeting
Presiding .....Mrs. Charles B. Stacy

STATE CONVENTION COMMITTEE

General Chairman .....Mrs. Parnell Rollings
Louisville
Registration .....Mrs. Donald Chatham
Shelbyville
Style Show Luncheon .....Mrs. David Kinnard
Louisville
Hospitality and Hospitality Room
Mrs. T. J. Overstreet
Lexington
Publicity .....Mrs. Glenn Bryant
Louisville
Flowers .....Mrs. Richard Gott
Louisville
Finance .....Mrs. Fred Williams
Louisville
Hostess for Tea McCracken County Auxiliary

WOMAN'S AUXILIARY TO THE KENTUCKY STATE MEDICAL ASSOCIATION
1955-1956
State Officers

President .....Mrs. R. Ward Bushart, Fulton
President-Elect
Mrs. Charles B. Stacy, Pineville
Vice-President
Mrs. William H. Cartmell, Maysville
Vice-President
Mrs. C. Melvin Bernhard, Louisville
Vice President .....Mrs. G. B. Froage, Paducah
Vice-President ....Mrs. William C. Cloyd, Richmond
Recording Secretary ...Mrs. J. O. Mattax, Carrollton
Corresponding Secretary
Mrs. J. C. Hancock, Fulton
Treasurer .....Mrs. B. T. Harris, Lexington
Parlamentarian ...Mrs. Garnett Bale, Elizabethtown

Advisory Committee

John S. Harter, M.D., Louisville, Chairman
R. Ward Bushart, M.D., Fulton
Samuel Warren, M. D., Lexington

Immediate Past Presidents

Mrs. David Woolfolk Barrow, Milwaukee, Wisconsin (resigned)
Mrs. Clyde C. Sparks, Ashland
Mrs. Karl D. Winter, Louisville

District Councilors

1st—Mrs. W. J. Petway, Paducah
2nd—Mrs. William W. Wainer, Providence
3rd—Mrs. George Rodman, Greenville
4th—Mrs. Lyman Hall, Campbellsville
5th—Mrs. Carlisle Morse, Louisville
6th—Mrs. Arthur D. Donnelly, Jr., Bowling Green

7th—Mrs. Wyatt Norvell, New Castle
8th—Mrs. W. Vinson Pierce, Fort Thomas
9th—Mrs. J. E. McKinney, Maysville
10th—Mrs. John Prewitt, Lexington
11th—Mrs. O. P. Clark, Winchester
12th—Mrs. Julian Wright, Stanford
13th—Mrs. C. I. Haeberle, Russell
14th—Mrs. John W. Bailey, Wheelwright
15th—Mrs. Samuel H. Flowers, Middlesboro

Committee Chairmen

American Medical Education Foundation: Mrs. Jesse T. Funk, Bowling Green
Benevolence: Mrs. Clark Bailey, Harlan
Bulletin: Mrs. Charles C. Kissinger, Henderson
Cancer: Mrs. Maurice Kaufmann, Lexington
Civil Defense: Mrs. J. A. Outland, Murray
Doctor's Shop: Mrs. Carroll Price, Harrodsburg
Finance: Mrs. J. Murray Kinsman, Louisville
Heart: Mrs. J. A. Poe, Fulton
Historian: Mrs. Philip E. Blackerby, Louisville
Legislation: Mrs. Garland Clark, Winchester
McDowell House: Mrs. Walker Owens, Mt. Vernon
Mental Health: Mrs. Irving Gail, Lexington
Nominations: Mrs. Karl D. Winter, Louisville
Nurse Recruitment: Mrs. Robert Reeves, Paducah
Program: Mrs. J. Andrew Bowen, Louisville
Public Relations: Mrs. Earl W. Roles, Louisville
Revision: Mrs. John S. Harter, Louisville
Rural Health: Mrs. Garnett J. Sweeney, Liberty
Today's Health: Mrs. A. B. Colley, Owensboro
Tuberculosis: Mrs. Merle M. Mahr, Madisonville
Blue Grass News Editor: Mrs. E. W. Jackson, Paducah
Publicity: Mrs. Glenn Bryant, Louisville

PROPOSED AMENDMENTS
to the
CONSTITUTION AND BY-LAWS
of the
WOMAN'S AUXILIARY
to the
KENTUCKY STATE MEDICAL ASSOCIATION

ARTICLE VII Section 3 page 5 ADD another paragraph: "Members-at-large, in good standing, upon application to the President may be named to serve as voting delegates to the convention. No more than 25 members-at-large shall be accredited (except as they serve in other classifications); no more than one from a county and they shall be accepted in order of application.

Scientific Movies Replace TV at 1956 Annual Session

Carefully selected scientific movies will be a prominent feature of this year's Annual Meeting, according to Rudolf J. Noer, M.D., chairman of the Subcommittee on Scientific Assembly. The movies will run from 8 to 10 each morning—simultaneously with the post-graduate refresher courses.

"Extreme care has been taken to insure as wide a coverage as possible and to include not just operative technique but rather general matters of diagnosis and treatment and considerations in the management of various disorders which are common problems in the day to day life of the average general practitioner," Dr. Noer, head of the Department of Surgery at the U of L Medical School, said.

Present plans for the films, which will be selected from the library of Davis and Geck, include the showing of a series of films on gall bladder diseases, and presentations on such subjects as: varicose veins, treatment of diabetic functions, tendon injuries, cancer of the breast and stomach, rectal and anal lesions and intestinal obstruction.

10 Class Reunions Scheduled September 20 in Louisville

Ten classes of the University of Louisville School of Medicine will hold reunion cocktail parties and dinners at the Brown Hotel in Louisville, September 20. The reunions held in conjunction with the Annual Meeting, will according to Les Shively, director of alumni relations of the University of Louisville, be in honor of classes: '06, '11, '16, '21, '26, '31, '36, '41, '46 and '51.

The faculty of the medical school will sponsor its third annual cocktail party in the Roof Garden of the Brown from 5 PM to 7PM.

A dinner in the Crystal Ballroom will immediately follow the cocktail party. Oscar Miller, M.D., Louisville, '11, will be the featured speaker.

J. Murray Kinsman, M.D., Louisville, dean of the medical school, extended an invitation to all KSMA members to attend the cocktail party.

Following is a list of physicians who will serve as arrangements chairmen for the reunions:

Class of 1911, Oscar Miller, Louisville
Class of 1921, W. B. Troutman, Louisville
Class of 1926, Armand Fischer, Louisville
Class of 1931, Byron Bizot, Louisville
Class of 1936, George McAuliffe, Louisville
Class of 1946, McHenry Brewer, Lebanon
Class of 1951, Letitia Kimsey, Louisville

Chairmen for the 1906, 1916 and 1941 classes have not yet been named.

The American Goiter Association has again announced the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. Essays can be written on either clinical or research investigations and should not exceed 3,000 words. Send the completed essays in duplicate typewritten copies double spaced, in English to John C. McClintock, M.D., 149½ Washington Avenue, Albany 10, New York not later than January 15, 1957. The award will be given at the annual meeting of the Association in New York May 28-30, 1957.



The Kentucky State Medical Golf Association tournament will be held at the Louisville Country Club September 17-20. Physicians are invited to play every day of the tourney, but only the score made the first day of play will count in the contest for the tournament prizes.

'56 Golf Tournament to be Held at Louisville Country Club

The Louisville Country Club is the site of the 1956 annual Kentucky State Medical Golf Association tournament, September 17, 18, 19, 20, according to Robert C. Long, M.D., chairman of the golf committee.

Dr. Long said that although physicians and guests could play every day of the tournament only the score made the first day of play would count in the contest for the tourney prizes.

Three traveling trophies will be awarded to the winners in the low gross, low net and senior championship classifications. These winners will receive permanent awards also. In addition attractive day prizes will be given to low gross and low net scorers.

Paul B. Hall, M.D., Paintsville, took top honors last year. Other 1955 winners were: J. T. Overstreet, M.D., Lexington, low gross senior trophy; and Joseph Humpert, M.D., Covington, handicap honors.

Annual dues for membership in the golf association are $5.00. Mail these dues to the secretary of the KSMGA at the Headquarters Office, 620 South Third Street, Louisville.

Other members of the golf committee are: Clifton M. Follis, M.D., Kenton Leatherman, M.D., Robert Riechert, M.D., and William Wolf, M.D.

'56 Annual Meeting Will Honor KSMA's President in 1876

The 1956 KSMA Annual Meeting will be held in honor of the eighteenth president of the Association, J. A. Hodge, M.D.

Dr. Hodge, according to Emmet F. Horine, M.D., Brooks, KSMA historian, was president of the association in 1876.

Since 1935 the KSMA has memorialized a past president of the association or some distinguished Kentucky physician. Last year's meeting honored Jerman Baker, M.D., president in 1875.

Special Bus Stop Arranged

A special arrangement has been made to have both north and south bound Fourth Street City busses accept and discharge passengers directly in front of Columbia Auditorium during the Annual Meeting September 27, 28 and 29. This service for K.S.M.A. members, their wives and guests, was made possible through the courtesy of John S. Akers, Jr., Superintendent of Schedules of the Louisville Transit Company.

Call Physicians at WA 6903

This year, for the seventh straight year, physicians attending the KSMA Annual Meeting at the Columbia Auditorium in Louisville September 18, 19, and 20, can be reached by calling WAbash 6903.

This telephone set-up is made possible through special arrangements with the Southern Bell Telephone Company and Columbia Auditorium. Physicians attending the meeting can make outside calls at any of the four booths located near the main entrance of the building.

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 AUGUST, 1956 NO. 8

UROLOGIC PATHOLOGY OF INTEREST TO THE GENERAL PRACTITIONER*

FRANK WOODS, M.D.
Miami, Florida

THE complexities of general practice have been multiplied so extensively that I feel justified in reviewing in a very broad sense certain urologic diseases. The vast majority of these can be handled by the general practitioner and the minority must have a more extensive urologic investigation. One must recognize those conditions that should be referred to a urologist early enough to allow diagnosis and treatment. My remarks will concern five categories: Congenital deformities, stones, neoplasms, infections and hematuria.

Symptoms and Signs

Symptoms referable to the urinary tract, such as frequency, strangury, difficulty, pain, incontinence and hematuria need only be mentioned to focus attention on the proper system for investigation. But do not forget that the nerve supply of the urinary tract is so intimately connected with that of other internal organs that referred pains of a reflex nature may appear to rise from pathology of the stomach, intestines, gall bladder, appendix, spleen, pancreas or elsewhere, when actually the pathology is urinary. Pain is always a challenge and demands a search for the underlying cause. Digestive symptoms of nausea, vomiting and ileus are frequently caused by ureteral obstruction. Pain in the testis is commonly caused by a low ureteral stone. The most common operation for right nephroptosis is appendectomy. Pain in the region of the gall bladder or appendix commonly results from right kidney or ureteral troubles, and appendicitis may often be confused with an acute right seminal vesiculitis. At this point I want to emphasize the importance of the rectal digital examination, which is so distasteful to a large number of otherwise capable doctors who would think nothing of feeling for a stone in Wharton's duct in the presence of a putrefactive pyorrhoea, but are too dainty to stick a finger in the rectum where any number of pathologic conditions and organs can be palpated, such as stricture, hemorrhoids, the prostate, infected crypts, polypi, tumors and the seminal vesicles, to mention only a few. The rectal digital examination is important on any age person. This has been proved by the finding of a prostatic tumor in a four year old boy. Too many patients with chills and fever are automatically treated for "virus" without examining the prostate or the urine.

Hematuria

Blood in the urine, whether gross or microscopic may be caused by a multitude of disorders. It may be caused by constitutional diseases such as nephritis and blood dyscrasias that concern the general practitioner and internist. Drugs such as anticoagulants, so popular at present in cardiovascular disease, and sulfa drugs, may cause it. Tumors, infections, deformities, injuries and foreign bodies, including stones anywhere from the kidneys to the urethral meatus must be considered. Painful hematuria is commonly associated with inflammatory conditions, foreign bodies and stones or a process causing obstruction. Painless hematuria frequently indicates a tumor. It may be the first symptom and never manifest itself again for months while the pathologic process is pro-

*Presented at the 1955 KSMA Annual Meeting, Sept. 28-30 in Louisville.

gressing beyond control. All patients who have hematuria deserve a thorough urologic investigation. Intravenous urograms are frequently of inestimable value but they are limited in scope. In my opinion, cystoscopy is mandatory and should be done during the time of the gross bleeding. Many patients with large bladder or kidney tumors give a past history of a short bout of hematuria one or two years previously, but they decided it was not important because it stopped.

In an analagous sense, do not assume that a stone has passed when the pain stops. The patient deserves extensive examination in the care of colic, including X-rays when possible to determine whether a stone is causing the trouble and, if so, whether it is of such size that it will pass spontaneously through the urinary channels. Any stone six mms. or over is apt to become impacted and possibly destroy a kidney before it passes.

Congenital Deformities and Infection

As for congenital deformities, almost anything can occur in the urinary system and frequently does. Duplication, displacement, horseshoe kidneys, pinpoint urethral meatus, strictures, diverticula, anomalous openings, contracted bladder neck, valves, hypertrophied veru and extrophy are enumerated for your consideration. Hydronephrosis frequently results from obstruction anywhere along the urinary tract. A congenital deformity in itself is not always important and may require no correction if it functions properly and does not cause disturbing symptoms or interfere with the function of adjacent viscera. Whenever stasis occurs, the function of the kidney is disturbed and frequently this is progressive, causing degenerative changes. Also, whenever stasis occurs, infection is encouraged and is difficult to eradicate by administering antiseptic drugs. In a child or in an adult, if the infection persists after the usual antiseptics are given the patient should have the benefit of further urologic study to look for congenital deformities or some other complicating factor. The antiseptics and antibiotics we have today will cure almost any uncomplicated infection, but when stasis exists, it is almost impossible to eradicate it.

Antibiotics such as tetracycline, terramycin® and others will probably kill a wide variety of organisms, both bacillary and coccal. Penicillin is of especial value in coccal infections, but will have no effect on the commonest invader of the urinary tract, the colon group of bacilli. Soluble sulfonamides are less expensive and very efficacious in bringing about destruction of a wide variety of organisms. In large institutions it has become common practice to perform ultra scientific tests, such as cultures and sensitivity tests, to determine which is the drug of choice for the bacteria found. It must be remembered that this is a test tube reaction and only gives helpful information in treating the patient. The bacteria and the resultant toxins must be overcome by the body's defense mechanism which is not always in accord with the test tube reaction. If cultures are made, it is advisable to do them before starting the treatment, but once the culture has been started, a broad spectrum antibiotic or antiseptic drug should be given. Many times the infection will be eradicated by the time the laboratory report is returned. Do not lose sight of some of the older antiseptics such as Urotropin® and mandelic acid, which still have value, and many of you have no doubt given arsphenamine for coccal types of urinary infection.

Stones and Foreign Bodies

Foreign bodies, including stones, may occur at any age. Pencils, pins, thermometers, glass stirring rods and even slippery elm have been recovered from the urinary bladder. Rarely gunshot ends its trajectory in the urinary tract, but shrapnel has been removed from the kidneys and in one instance, to my knowledge, a bullet was removed from the shaft of the penis in a war injury. Stones are formed of chemical substances normally found in the urine. By far the majority are alkaline in composition and cast a shadow on X-ray. They are commonly combinations of calcium and inorganic salts such as phosphates and oxalates. Uric acid, urates, carbonates, xanthine and cystine are elements involved in stones less commonly. The clinical significance of stones is largely two-fold; they are frequently associated with infection and they may produce stasis and degenerative changes. Most stones up to six mms. in size will pass spontaneously. Most larger stones require surgical removal. Stones less than one cm in size in the kidney pelvis or calyces are frequently X-rayed periodically for observation, since surgical removal might result in considerable damage from trauma to the kidney in locating the stone.

Bladder stones can frequently be removed by cystoscopic means and crushing procedures. It must always be kept in mind that a high percentage of bladder stones are caused by stasis and the latter condition should be corrected to prevent recurrences.

Neoplasms

Tumors of the urinary tract may occur from the kidney tubules, the pelves, ureters, bladder, prostate and urethra. Most of these are epithelial in origin; however, some are derived from connecting tissues. Papillomatous tumors of the bladder are always clinically malignant, even through the pathologic findings in the removed portions are reported as benign. They should be destroyed by fulguration or radiation, or surgically removed. X-radiation and radium frequently result in chronically painful conditions of the bladder and should be used with care. Extensive tumors of the bladder without obvious metastasis sometimes require complete cystectomy with transplantation of the ureters to the skin or bowel. Papillomatous tumors are not uncommon in the kidney pelves and ureters, but are considerably less frequently seen than those in the bladder. Kidney tumors invading the parenchyma of the kidney are almost always malignant and unilateral and require nephrectomy if the other kidney is normal. The great majority are carcinomatous. The classical triad of symptoms, pain, hematuria and enlarged kidney, should always prompt immediate study by pyelograms. Papanicolou studies of the urine are considered of very little value since other methods are more accurate. Aortography, with or without pyelograms, is of value in differentiating cysts from solid tumors of the kidney, and has value in determining the vascularity, but I must maintain that surgical inspection is far superior once the tumor has been localized in the kidney.

THE PAPANICOLAOU PROCEDURE AS AN AID IN THE EARLY DIAGNOSIS OF CANCER OF THE CERVIX*

W. Vernon Lee. M.D.
Covington

THE VAGINAL smear method was introduced by George N. Papanicolaou, M.D., who in 1928 described the malignant cells of the uterine cancer by smears from the vaginal fluid. Our introduction to the vaginal smear method came through the enthusiasm of Daniel Richfield, M.D., pathologist at the Booth Memorial Hospital, who studied with Dr. Papanicolaou. His training overcame our natural reluctance as physicians, to base the diagnosis of malignancy on exfoliative cells. The study at Booth Hospital began in 1950 when 46 smears were examined. Of that group, one was reported as suspicious and two were positive. In 1951, 157 smears were presented. Five of these were suspicious and eight were positive. In 1952, of 648 smears presented, 17 were suspicious and 13 were reported as positive. In 1953, of 1,005 smears submitted, 17 were suspicious and 14 were positive. In 1954, 1,276 smears were presented to the cancer lab and 29 were reported as suspicious and 17 as positive. In the first six months of 1955, 818 smears were sent to the cancer laboratory. Of these 17 were suspicious and 21 were positive. The cytology report form calls for the patient's name, the date, the physician's name and the site of the smear: vaginal, cervical, other. The report is given in five classes: Class 1—no atypical or abnormal cells (negative): Class 2—atypical cells without abnormal features (negative): Class 3—cells atypical but not pathognomonic (suspicious): Class 4—moderate number of neoplastic cells: Class 5—large number of neoplastic cells.

Statistics and Cases

I am going to report to you the following statistics regarding the 170 smears that I have sent from my office to the Cancer Clinic. Nine of these were reported as positive or class 4 and class 5. Three were in the Class 3 or suspicious group. Two of the nine so far have proved to be false positives. In the suspicious group, a 70 year old patient had a grade 3

**Presented at the 1955 KSMA Annual Meeting in Louisville, Sept. 28-30.*

squamous cell carcinoma of the vagina. In another suspicious group, a 65 year old colored woman, who had a large fibroid tumor with post-menopausal bleeding, had a proved adenocarcinoma of the endometrium with extension into the cervix. A 39 year old patient had a Papanicolaou reported in the class 3 of the suspicious group and she had a precancerous metaplasia of the cervix.

The remaining seven patients of the positive group, that being class 4 and 5, showed that four had preinvasive carcinomas—these will be discussed in more detail later—two had invasive carcinoma of the cervix. One patient had an early carcinoma of the cervical stump. This patient had a sub-total hysterectomy performed eight years ago. More specific history concerning the preinvasive group, patients who had come to the office for other reasons than gynecological examinations, is as follows:

The first patient was a woman, 35 years of age, who was seen at the hospital several months previously in consultation for cholecystitis. On a post-operative checkup, she mentioned the fact that she had had some irregular bleeding and a Papanicolaou smear was reported as class 4. Biopsies were taken and they revealed preinvasive carcinoma. The patient was treated with total hysterectomy.

The second patient had preinvasive carcinoma which was proved by biopsy after a clue was given to us by a class 4 Papanicolaou smear.

A 60 year old woman came to the office for examination concerning hemorrhoids. Another patient, age 33 years, came to my office in consultation concerning cholecystitis and during a routine physical examination, erosion was seen on the cervix so a Papanicolaou smear was taken and it also revealed a class 4. Biopsy proved this to be a preinvasive carcinoma.

Another patient, age 34 years, was seen in the office for a tumor in the right axilla. Routine history and physical examination was done and a Papanicolaou smear was taken which revealed class 4 and preinvasive carcinoma of the uterine cervix.

Two cases which showed a class 5 Papanicolaou smear did not fit into the picture of the title for this paper, that being "The Papanicolaou Procedure as an Aid in the Early Diagnosis of Cancer of the Cervix." It seemed very obvious that the patients had carcinoma of the cervix, and the Papanicolaou smear was taken for academic interest. One of the patients, 60 years of age, a widow of a physician, was seen in consultation at the request of an internist because of uterine bleeding so severe the patient was in shock. A Papanicolaou smear was made and neoplastic cells were found. Biopsies were taken at the same time. The diagnosis was squamous cell carcinoma. Another 60 year old patient was seen in the office because of post-menopausal bleeding. A lesion was noted on the cervix and Papanicolaou smear revealed a class 5. Biopsies made at the same time revealed squamous cell carcinoma.

In the false negative group, a 31 year old patient came to the office with a history of metrorrhagia. A dilatation and curettement procedure was recommended to the patient. The uterine scrapings revealed squamous cell carcinoma. Probably one of the reasons this was not obtained on the Papanicolaou smear was because there was marked cervical stenosis. Another patient had a class 2 Papanicolaou smear and an endometrial carcinoma which was proved by curettement.

In the false positive group, one 20 year old girl was admitted to the hospital for a currettement and cervical biopsies. I am not entirely satisfied and will study this patient again. In the case of another false positive, a 23 year old patient, curettement and biopsies revealed focal abscesses. Remember the statement of Dr. Panpanicolaou, "The smear should be used as a preliminary sorting procedure and should be confirmed by biopsies and tissue diagnosis." Justification of the method was presented in a monograph published in 1943 by Dr. Papanicolaou. Other reports were made by Meigs and his group and more recently by other workers and they illustrate the peculiar advances of the vaginal smear which suggests that it may be a means to observe the first stages of cancer and possibly the transition between benign and malignant lesions.

Usefulness of Smear

The cases in which the smear may be particularly helpful are: 1. Those cases with symptoms compatible with carcinoma but with negative findings on inspection and palpation; 2. Those with symptoms compatible with carcinoma in which biopsies and scrapings are not justified; 3. Cases in which there is suspected carcinoma and biopsies and scrapings are negative; 4. In those cases discovered by means of

routine use of the method when the patient has presented herself for a physical examination for another disorder.

The practicability of the smears as a screening test for early discovery of the stages of cancer all depends on whether the exfoliated malignant cells are in a stage sufficient for diagnosis, whether the number of cases discovered is great enough to justify the use of this method and whether false impressions can be avoided. False positive diagnosis can be prevented only by proper study. The number of malignant cells in each smear will vary. In some cases of carcinoma, there might be a number of malignant cells in a smear. Again in a slide with extensive carcinoma, there might be only one or two cells present. Cancer cells are more likely to degenerate—this tendency becomes greater with loss of differentiation. The number of cells in a smear may be indirectly related to the degree of malignancy. These will be determined by the presence or absence of necrosis and by the surface area of the lesion. In any clinically suspicious case of carcinoma, a negative smear cannot be depended upon to exclude the diagnosis of cancer. Specific sources of error could be chronic inflammation with large histiocytes; degeneration of glands; endometrial hyperplasia; hyperplasia of the cervical cells; decreased ovarian function and radiation changes.

Summary

The Papanicolaou procedure as an aid in the early diagnosis of cancer of the cervix has been discussed. Brief resumes of cases from an office practice have been presented. With the progressively increasing interest in the method by the medical profession and with the better preparation of cytological materials submitted for examination, great advances in the early diagnosis of many types of cancer may come in the near future.

References

1. Papanicolaou, G. N. and Traut, H. F., *Diagnosis of Uterine Cancer by the Vaginal Smear.* The Commonwealth Fund, New York, 1943.

2. Meigs, J. V., et al; The Value of the Vaginal Smear in the Diagnosis of Uterine Cancer. *Surg., Gynec, and Obst.,* 1945, *81,* 337-345.

VARIATIONS IN THE DISEASE, PULMONARY TUBERCULOSIS*

E. M. Medlar, M.D.
Ithaca, New York

YOU MAY WONDER as I did why a pathologist should be asked to talk on the disease, tuberculosis, since with the firm establishment of chemotherapy as the treatment of choice there has occurred a considerable decrease in the death rate from the disease. There are many who now seem to think that tuberculosis is on its way out and many tuberculosis associations are casting eager eyes in other directions with the idea that soon there will be no tuberculous problem with which to deal. From where I sit on my bench in the laboratory, it is my impression that the tubercle bacillus is not nearly as depressed as the lay press and many physicians seem to think.

A Pathologists Viewpoint

There are perhaps two reasons why a pathologist should talk on the subject of tuberculosis at the present time. The first of these concerns the nature of the pathology that remains after many months of efficient combined chemotherapy. This will be the subject of a later discussion.

The second reason pertains to the present trend of treating tuberculous patients at home instead of in tuberculosis hospitals. I do not intend to trespass upon the prerogatives of clinicians to treat sick people as they see fit. As a matter of fact this subject is entirely outside the field of the proper functioning of the pathologist. I have noticed however that there are now empty beds in most tuberculosis hospitals and that more and more persons found to have tuberculosis are resisting the idea that they should enter these institutions for treatment. One effect of this trend is that those who hold the purse strings of the public funds are becoming less and less interested in tuberculosis, a still unsolved problem, and funds to properly

**Presented at the 1955 KSMA Annual Meeting in Louisville, Sept. 28-30.*

run tuberculosis hospitals are being curtailed. There is even an urge to close tuberculosis hospitals. This, I am sure, the tubercle bacillus would welcome.

Probably it was a mistake in the first place to isolate the problem of tuberculosis in separate hospitals, but at the time this program was put in effect the main effort was to take infectious persons out of circulation. This has had the unfortunate effect of making the treatment of tuberculosis a specialty and the large majority of physicians have washed their hands of the problem. If the present trend to treat tuberculous cases at home and by the general physician continues there will inevitably be greater responsibility thrown upon the practicing physician if the problem of tuberculosis is not to worsen in the future. The treatment of the tuberculous patient is far more complicated than the prescription of effective chemotherapy agents until the patient feels clinically well. Tuberculosis has always been a most difficult disease to evaluate clinically. When the disease is first discovered, it commonly is in an advanced stage. In spite of the considerable campaign to discover the disease in its "early" stage about two-thirds of the newly discovered cases continue to have advanced disease. Any attempt to "date" the onset of the disease from clinical history usually is most unsatisfactory. An advanced case may be of no longer and may be of shorter duration than a case of minimal disease. Too often a considerable amount of disease may be found in an individual who is in a state of seemingly good health. It is not feasible to determine the status of such disease from a single X-ray of the chest. From serial X-rays a better idea may be obtained, but here again what meets the eye is often deceptive.

Such patients often claim that they raise no sputum and recourse to cultural studies of fasting gastric contents may or may not reveal the presence of tubercle bacilli. Although sputum and fasting gastric studies, especially cultures, are now recognized as a very important part in the study of tuberculous cases, it is becoming generally recognized that failure to demonstrate tubercle bacilli by such methods does not indicate their absence in lesions in the lung. I have had the opportunity to study pulmonary tissue resected after many months of chemotherapy from patients on whom repeated sputum and fasting gastric content studies failed to reveal any bacilli; however, within the necrotic pneumonic lesion bacilli in large numbers were found.

The Behavior of Tuberculosis

These remarks have been made to emphasize the fact that the manifestations and behavior of tuberculous disease of the lung are both erratic and unpredictable. The reason for this is related directly to the complicated pathological process that is tuberculosis. In my opinion, it is pertinent to discuss this complicated pathological process, especially for the benefit of the general practicing physician, for I doubt that he has been "exposed" to this problem during his medical course any more than I was and my exposure was slight indeed. I am not aware that any more time is allotted in medical curricula today to the teaching of the dynamics of tuberculosis than was allowed 40 years ago. This situation will have to be changed if in the future the general practitioner is going to accept the responsibility of caring for tuberculous patients at home.

My discussion will deal with variations in the pathology found in tuberculous patients who have received little treatment of any kind and no chemotherapy. The material to be discussed has been obtained from resected pulmonary tissue, from patients who died from causes other than tuberculosis and from patients who died from tuberculosis shortly after a first diagnosis of the disease had been made. Discussion of material of this nature serves two purposes. First, it will show how variable the pathological picture may be in untreated tuberculous persons. Secondly, it will serve as a base for an evaluation of the effect upon this variable pathological process of the present day chemotherapeutic treatment. In my opinion, it is impossible to evaluate the effect of chemotherapy without a thorough understanding of the many variables that may be present in untreated tuberculous persons.

It would seem that progressive pulmonary tuberculosis is initiated by the liquefaction and sloughing through the connecting bronchus of an initial small focus of tuberculous lobular pneumonia. The amount of pulmonary disease that results from this process depends upon the amount of the slough that is scattered through the bronchi to lung tissue which previously had not been involved. It is in the behavior of the new areas of disease that the two major com-

ponents become evident. These may be designated as the non-necrotic and the necrotic component. The non-necrotic component consists of areas of pneumonia in which tubercle bacilli are either very few in number or absent altogether. This portion of the disease may largely resolve like other types of lobular pneumonia or, more often, numerous epithelioid tubercles and giant cells are formed. These latter structures heal by scar formation and it is this portion of the tuberculous disease that creates the major portion of parenchymal scarring. This component commonly heals completely and the only after-effect on the patient is a lessened pulmonary function if the parenchymal scarring is considerable.

Unfortunately, the new areas of tuberculous pneumonia usually are composed in part of lesions which undergo necrosis and the proportional relationship between the non-necrotic and necrotic components varies widely from one area of disease to another and from one case to another. The necrotic lesions indicate those areas in which tubercle bacilli have been most numerous. The process of necrosis appears to be a product of the reaction of the host rather than to be related directly to the action of the bacilli, for in this process large numbers of bacilli disappear from the lesions, apparently lysed. On the other hand, if all bacilli are not destroyed, then those remaining too often find it possible to reproduce after necrosis is complete to large numbers, sometimes in large colonies, and it is this bacteriological situation which makes the necrotic focus a considerable potential hazard.

The Threat of Slough

The real threat which the necrotic area of tuberculous pneumonia presents is that there is an unpredictable tendency for Nature to liquefy and slough the necrotic tissue through the connecting bronchus. It seems to be a general law in nature to slough dead tissue if possible, and this applies to tuberculosis. It is well illustrated by the sloughing of tuberculous cervical lymph nodes and by the formation of Pott's abscess. The same process occurs in the tuberculous lung.

The danger inherent in the delayed sloughing of areas of necrotic tuberculous pneumonia lies in the viable bacteriological content of the sloughing lesion. If the bacteriological content is insignificant or non-existent the sloughing is not of great significance even if new areas of disease may become evident radiologically. If on the other hand the bacteriological content is high then new areas of disease that too often accompany the sloughing indicate a serious situation. Unfortunately, it is impossible to distinguish, radiologically, between these two situations early and it is only the behavior of the new shadows, as evidenced in serial X-rays of the chest, that the difference between the two conditions can be appreciated. In the period before chemotherapy, it was well known that all "spreads" of tuberculosis were not life threatening and it was also well understood that only time could reveal which were and which were not. This is, perhaps, the outstanding and the most perplexing problem in the management of tuberculous patients and it needs re-emphasis now that chemotherapy has come to dominate the thought with regard to the treatment of tuberculous patients.

The age of the individual is not the deciding factor in the course of the disease. It seems that at no age is there an absolute "immunity" to the disease, even if an individual had received a natural vaccination with virulent tubercle bacilli and had completely healed that infection. The major problem in tuberculosis occurs in those of middle age or older. In my opinion, this has always been the situation, although for a long time it was stressed that tuberculosis was primarily a disease of the young. To me it is quite evident that there must be an increased awareness of the problem of tuberculosis among older persons by the general practicing physician if a continued reduction in the number of new tuberculous cases is to be achieved. Also it must be more fully appreciated that serious advanced tuberculosis in a person in later life may represent an infection of fairly recent origin, not one that was acquired in childhood. Finally, it should be evident that pulmonary shadows which have remained "stationary," roentgenologically, more often than not represent smouldering, unhealed, tuberculous disease. Such cases should be followed with periodic X-rays of the chest indefinitely, for there is no way, at present, to determine whether or not a serious progressive disease may develop. A "spot" in the lung should not be regarded lightly and forgotten for at a later date that individual may become a potent spreader of tubercle bacilli and the unrecognized source of new cases.

Conclusion

In my opinion there never has been a time when the general practitioner has been faced with such great responsibility with regard to the problem of tuberculosis as at present. Unless he is on talking terms with the complicated pathological problem that is inherent in this disease, it is doubtful that he will be able to discharge this responsibility with credit.

THE MEDICAL MANAGEMENT OF LIVER DISEASE*

J. Richard Gott, Jr., M.D.
Louisville

BECAUSE of the many functions, both metabolic and secretory, which the liver performs, there is a multiplicity of physiological disturbances which the diseased liver may present. Accordingly, liver disease, both acute and chronic, is usually treated with a combination of procedures thus making it difficult to assess accurately the value of any particular therapeutic method or agent.

It is the purpose of this paper to present some of the present day concepts concerning the management of liver disease and to discuss briefly the physiological implications of some of the procedures being used. Acute viral hepatitis will be discussed as an example of acute hepatitis and Laennec's (alcoholic; portal) cirrhosis as an example of chronic liver disease. The therapy presented will in general apply to other forms of either acute or chronic liver disease, but specific liver disorders may present special problems not covered in a presentation of this brevity.

Acute Viral Hepatitis

Rest. Studies made during the Mediterranean Campaign of World War II[1] showed the advantages of prolonged bed rest and pointed out the higher incidence of relapse and chronicity in soldiers returning to duty before complete recovery. A post-war study on soldiers in occupied Germany,[2] who were undoubtedly better nourished and in better physical condition at the onset of their illness than those in the Mediterranean Campaign, showed that the patients did well on shorter periods of bed rest and restricted activity and suggested that probably the longer period of bed rest was not necessary. Something can be learned from both of these studies. Specifically we believe that it is desirable for patients to remain at bed rest until they have begun to feel well, the liver has diminished in size, and their laboratory studies indicate a return toward normal. At this point, which will require two or three weeks in the average case, we believe it to be permissible to permit the patient to sit up and to have limited activity. If this has no unfavorable effect on the course of the disease, the activity may be gradually increased, keeping close check on the size of the liver, how the patient feels, and the behavior of the liver function tests, particularly the serum bilirubin level. It is felt that there should be some restriction of activity until the disease has completely run its course and the liver function tests, such as the BSP excretion, cephalin flocculation and thymol turbidity, have returned to or are approaching normal. In the average case this requires eight to 12 weeks.

Diet. The studies on hepatitis cases during and since World War II seem to leave no doubt that these patients do best on a diet ample in calories and liberal in protein and carbohydrate. Fat in the diet is no longer considered to be contra-indicated, at least not in amounts necessary to make the diet palatable. It is our custom to use a diet of 2600-3000 calories, containing 300-500 gms. of carbohydrate and 150-200 gms. of protein. The caloric level of the diet is determined by the patient's nutritional needs and the relative proportions of protein, carbohydrate and fat

*Presented as a part of the 1956 Spring Postgraduate Series conducted by the University of Louisville School of Medicine in cooperation with the Kentucky State Medical Association and the Kentucky Chapter of the American Academy of General Practice.

From the Medical Service, Veterans Administration Hospital, Louisville, Ky., and the Department of Medicine, University of Louisville School of Medicine.

Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements made and the conclusions drawn by the author are a result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

are influenced by his personal food preferences. In acute hepatitis, ascites and edema are usually not a problem and if this is the case salt is permissible in amounts sufficient to make the diet appetizing.

If the diet is adequate in all respects there is felt to be no need for supplements to the diet such as choline, methionine, liver extract and the various vitamins. However, there is no objection to their use if the physician prefers to use them. The optimistic therapeutic promise, based on early experimental work on choline and methionine[3, 4, 5] which showed their lipotropic action and hence their ability to prevent or minimize fatty infiltration of the liver in experimental animals, was not borne out in clinical studies. The present feeling seems to be that if the diet is adequate in all respects there is no need for choline or methionine,[6] but if the diet is deficient, particularly in protein, there may be some justification for their use. If the patient cannot take an ample diet then it is necessary to make up for this inadequacy by giving the food either by stomach tube or parenterally or both. When protein hydrolysates are given intravenously it is well to bear in mind that if the dietetic intake is not sufficient for caloric needs the protein will be used for energy purposes just the same as if it were glucose. Accordingly, it is important that the food intake be adequate for caloric needs.

Vitamin K requires some special consideration. Its deficiency may occur as a result of obstructive processes in which bile is not delivered into the intestinal tract and therefore the Vitamin K in the diet is not absorbed, or because damaged liver cells cannot use it to form prothrombin.[7] When either occurs the prothrombin time may become sufficiently prolonged to cause bleeding. Vitamin K, then, should be used in any case when the prothrombin time is prolonged. Whether or not its administration will correct the increased prothrombin time will depend on whether the trouble is caused by a deficiency in vitamin K or by inability of the liver cells to use it. In the latter case its administration will not be helpful. Because of this dual metabolic consideration, vitamin K may be used as a therapeutic measure and as a liver function test.[8] Where there is a prolonged prothrombin time either with or without bleeding, it has been our policy to use 72 mgms. of Hykinone® intravenously daily for three days and then to recheck the prothrombin time. This not only constitutes intensive therapy for vitamin K deficiency, but will also show whether the prolonged prothrombin time is caused by a deficiency in vitamin K or by the inability of the liver cells to use it. Hykinone® may be given in dosages of five to 15. mgm. daily, subcutaneously or intramuscularly, for prophylactic or maintenance therapy.

ACTH AND CORTISONE. There has been considerable use of corticotropin and cortisone, and more recently prednisone (Meticorten,®). in acute hepatitis.[9, 10, 11] The studies are not conclusive and for the most part do not show any definite modification of the course of the disease. In some cases, however, their use results in the patient feeling better and having a better appetite. In this respect their use could be said to have a beneficial effect on the behavior of the disease, if used in patients whose prominent symptoms were general malaise and loss of appetite. In this type of case it is our policy at present to use prednisone, 10 mgm. every six hours (40 mgm. daily) and after satisfactory symptomatic improvement has been obtained to reduce the dosage to five mgm. every six hours and to continue this dosage for one to two weeks, or as long as needed to produce a feeling of well being and to promote a good appetite.

SEDATIVES. Since many of the commonly used sedatives, such as paraldehyde, morphine, chloral hydrate, and the short acting barbiturates such as Penthothal® and pentobarbital, are inactivated by the liver the question of which sedative to use may cause some concern. Some cases, the milder ones in particular, tolerate any sedative well, but in the severe cases, even small doses of any sedative may result in an exaggerated or prolonged effect and may even be a factor in the development of irreversible hepatic coma. It is the general feeling at present that Demerol,® the bromides, and the long acting barbiturates such as phenobarbital and barbital, which are excreted in part by the kidneys, are the least hazardous sedatives. A realistic attitude would seem to be that the use of any sedative is fraught with some risk, especially in the severe cases with precoma symptoms, and that the use of even the supposedly better tolerated

sedatives should be attended with caution and careful observation.[12]

Laennec's Cirrhosis

REST. The same reasoning which was applied to limitation of activity in the treatment of acute liver disease applies to chronic liver disease. The decisions are made more difficult, however, because of the longer time element involved. It is generally believed that these patients should remain in bed during the acute exacerbations of the disease and that it would be preferable for them to remain in bed as long as there is continuing improvement in the clinical picture and in the liver function studies. Whenever the condition approaches normal or stabilizes, it is permissible to allow the patient to be up and about for short periods, providing this activity does not cause a worsening of the clinical or laboratory picture. Such activity may be gradually increased provided it causes no unfavorable signs but some restriction of activity would be indicated as long as there are any abnormal signs or symptoms. The serum protein levels, the cephalin flocculation and thymol turbidity tests, and the BSP excretion are important laboratory tests to use as guides. If facilities for such tests are not available, then the physician will have to rely upon his clinical judgment and those laboratory tests which he might have available to him.

DIET. In Laennec's cirrhosis and in other forms of chronic liver disease, just as in acute hepatic disorders, it is important that the patient have a diet adequate in calories and liberal in carbohydrate and protein. Again, if the patient's diet is adequate there is felt to be no real indication for the use of diet supplements such as methionine, choline, or liver extracts, but there is no objection to their use, or the use of vitamin B complex or multiple vitamin preparations if the physician wants to use them. It should be emphasized that proper dietetic therapy is probably the most important factor in the recovery of these patients and that it is a long drawn out affair, often requiring many months before encouraging results can be observed.

Most of the patients with Laennec's cirrhosis are heavy users of alcohol. While there is no conclusive evidence that alcohol in moderation is harmful if the diet is adequate in all respects, it most certainly is not helpful, and it is common experience that most of these patients are incapable of taking alcohol in moderation. Accordingly, we advise total abstinence.

There may be a prolonged prothrombin time in these cases, just as in the acute cases, either as a result of faulty absorption of vitamin K from the intestinal tract or because the liver cells are too badly damaged to form prothrombin. Again the indication for vitamin K therapy will depend on whether or not there is a prolonged prothrombin time, and its effectiveness will depend on the ability of the liver cells to use it properly.

ASCITES AND EDEMA. The retention of salt and water and the resultant formation of edema and ascites constitute one of the most trying problems in the cirrhotic patient. This ascites forms as a result of a combination of factors including low serum protein levels, portal hypertension, and possibly the inability of the damaged liver cells to dispose of the pituitary anti-diuretic hormone.[13, 14] Regardless of the roles of these contributing factors it has been a common clinical observation that if the patient's nutrition can be improved so that his serum albumin levels are brought back to normal, the ascites will clear up in a substantial number of these cases or at least will be considerably less of a problem. Accordingly, the best treatment for the ascites in the long run is the dietetic treatment which will bring the liver function and the serum proteins back to normal. In the interim, until such a desired nutritional state can be attained, the ascites can best be controlled by limitation of the salt intake and by the judicious use of mercurial diuretics. In cases where the edema and ascites are an urgent problem and where there is a low serum albumin level, the administration of concentrated human serum albumin intravenously may be helpful.

The question of how often to tap these ascitic cases and how much fluid to remove may cause some concern. It should be kept in mind that when ascitic fluid is removed, protein and salt are removed. When the ascitic fluid reforms, protein is taken out of the blood and salts (sodium, chloride, and other electrolytes) are withdrawn from the extra-cellular body fluid. [14, 15] This may result in an acute low salt syndrome characterized by signs of prostration, oliguria, uremia, and even shock. Such an oc-

currence is quite serious and may be fatal. If it occurs it should be treated by the prompt administration of normal or hypertonic saline solution. Since the removal of appreciable amounts of ascitic fluid is associated with some risk, we believe that this fluid should be removed only when the fluid is sufficient in amount to cause mechanical embarrassment to cardiac, pulmonary, digestive or renal function, and that then only enough fluid should be removed to relieve this pressure. This can usually be done by removing only three to six quarts of fluid instead of the three to six gallons which perhaps could be removed. We believe it is preferable to tap the patient more often rather than to remove a large amount of fluid at one time, if such a choice has to be made. For obvious reasons, if it is necessary to tap the patient frequently he should not be on severe salt restriction.

The limitation of salt intake, the frequent use of mercurial diuretics, the use of cation exchange resins, and the frequent removal of ascitic fluid, may contribute to the development of a chronic salt depletion, characterized among other things by ascites and edema that are refractory to diuretics. Studies on the serum of these patients will show the sodium and chloride levels to be low. When such a situation develops it is desirable to remove the salt restriction. After the sodim and chloride levels have returned to normal the patient's edema and ascites will again become responsive to salt restriction and mercurial diuretics.

Hemorrhage. Portal hypertension with bleeding from ruptured esophageal varices is one of the serious complications of chronic liver disease. Approximately 50 percent of the patients with such bleeding die within a year's time. In the management of the acute bleeding episode we have made it a policy to do x-ray studies of the upper gastrointestinal tract early in order to obtain better information as to the cause of the bleeding. This is desirable since in patients with esophageal varices, the acute upper gastrointestinal bleeding will be coming from peptic ulcer or lesions other than the varices in approximately one-third of the cases.[16] If the x-ray studies indicate that the varices are the probable source of the bleeding, conservative measures are tried first consisting essentially of rest flat in bed, three ounces of a half and half mixture of milk and cream at one or two hour intervals during the full 24 hours, and sufficient whole blood transfusions to maintain the blood count at low normal levels. If the active bleeding continues, then the Sengstaken-Blakemore double balloon tube is used in order to exert pressure against the lower end of the esophagus and to thereby compress the veins and stop the bleeding. If this is not effective, transesophageal ligation of the varices or one of several other surgical procedures may be indicated as an emergency measure to stop the hemorrhage. After the acute bleeding episode has been controlled, if indeed it can be controlled, then the advisability of performing a porta-caval or spleno-renal shunt operation, in order to relieve the portal hypertension, should be considered.[17] Time does not permit a full discussion of porta-caval shunts. Suffice it to say that if the portal hypertension can be corrected by connecting the portal with the systemic veins, it may prove to be a life saving measure. Because of the major aspects of the surgery itself, these patients must be reasonably good risks which means among other things that their liver function tests should be fairly good and that their serum albumin levels should be at or near normal.

Acth and Cortisone. Because of the chronicity and hence the long time factors involved, it is usually not desirable to use corticotropin or cortisone in chronic liver disease. During acute exacerbations when the patient's appetite is poor and there may be difficulty in getting the patient to take an adequate diet, the use of these agents may improve the appetite and his sense of well being and thereby assist in his nutritional management. When these agents are used prednisone is considered the drug of choice since it has less effect on salt and water retention.

Sedatives. The same reasoning which applies to the use of sedatives in acute hepatic disorders applies to the chronic forms. It might be mentioned, however, that because chronic alcoholism and delerium tremens are often associated with Laennec's cirrhosis, the problem of sedation may be an urgent one. Paraldehyde, a drug that is commonly used, is partially broken down by the liver, and hence should be used with caution. We would emphasize again that any and all sedatives should be used with caution in patients with severe liver disease, either acute or chronic, particularly if they are having mental symptoms which might be the forerunners of hepatic coma. It might also be

added that the so-called tranquillizing drugs are not free of danger. We have seen two cases of Laennec's cirrhosis go into irreversible coma while receiving Thorazine® and under conditions which made us feel that Thorazine® was a contributing factor in the development of the coma.

Hepatic Coma

The treatment of hepatic coma should be considered as part of the management of both acute and chronic liver disease since it may occur in either and is not an entity in itself. However, since it offers some special problems it is being considered separately.

The cause of hepatic coma is not known. It may occur in the severe forms of either acute or chronic liver disease and there are no laboratory tests that are pathognomonic of it. Most investigators who have studied the disorder prefer to consider that there may be several causes or mechanisms for its occurrence. It is known that fluid and electrolyte imbalances may be a factor in the occurrence of mental symptoms. It has also been pointed out that the liver cells destroy many toxins and that one or more of these mechanisms might be defective thereby allowing an accumulation of some toxin or toxins which produce the coma. Of a more positive nature, however, is the recent work showing that there is frequently a high level of ammonia in patients in coma, and also the clinical observation that coma often develops in patients who are receiving ammonium salts, either as salt substitutes or as ammonium chloride being used for diuresis.[18] It is believed that this faulty handling of ammonia by the liver cells (which usually convert it to urea) is a result of shunting the blood around the cirrhotic liver so that the liver cells do not have an opportunity to handle the ammonia, or because the damaged liver cells cannot perform this function properly, or because of a combination of both factors. Whatever the cause, the high concentration of ammonia is toxic and interferes with normal metabolic and oxidation processes in the brain, thereby causing the mental syndrome.

Because of this relationship of ammonia to coma, it is now considered desirable not to give ammonium compounds such as ammonium chloride or cation exchange resins containing ammonia to comatose or other severe cases. In the severe cases it has been shown that the ammonia obtained from the amino-acids in a high protein diet or from the breakdown of blood proteins following a massive hemorrhage into the gastrointestinal tract may precipitate a comatose state. For this reason protein, if permitted at all, should not be given in quantities exceeding basal requirements in precoma or coma cases. Because of their action in lowering blood ammonia levels, glutamic acid by mouth and sodium glutamate intravenously, in dosages of 20-30 gms. daily have proved effective in clearing the coma in some of these cases but their effect may be only temporary and they apparently do not affect the basic course of the disease.[19]

Corticotropin and cortisone have been found to be effective in the treatment of hepatic coma in some cases.[20] The initial dosage of cortisone has usually been 600 to 1000 mgm. daily or even higher. The mechanism of its effectiveness is not known. By correcting the coma and allowing the patient to take an adequate diet it may influence the course of the disease.

The use of Aureomycin® and Terramycin® has been advocated in the treatment of hepatic coma on the theory that they may fill a metabolic need of the liver cells, that they help prevent or control infection within the liver, or that by destroying bacteria in the bowel they diminish the bacterial action on protein and hence the formation and absorption of ammonia from the bowel. Since there is also evidence that Aureomycin® and Terramycin® may be harmful to the liver,[21] the status of these drugs as therapeutic agents in hepatic coma or other types of liver disease is at the present time in some doubt.

Summary

An attempt has been made to review the current concepts relative to the management of acute and chronic liver disease and to discuss briefly the clinical and physiological aspects of some of these procedures. It was emphasized that bed rest during the acute or active phases of liver disease and limitation of activity until complete recovery, together with a diet adequate in calories and containing high proportions of protein and carbohydrate, constitute the most important factors in therapy.

Special problems such as the use of corticotropin and cortisone, the choice of sedatives, the management of bleeding from esophageal varices, the treatment of ascites and edema, and

the indications for the administration of vitamin K were discussed.

The pathogenesis of hepatic coma was reviewed, emphasis being placed on the role of ammonia as a causative factor in some of these cases. It was pointed out that in the prevention and treatment of hepatic coma, compounds containing ammonia such as ammonium chloride, should not be used. It was pointed out further that the ammonia derived from the amino-acids in a high protein diet might be sufficient to aggravate or even precipitate a comatose state and that in the management of hepatic coma, protein, if permitted at all, should not exceed basal requirements.

References

1. Barker, M. H.; Capps, R. B., and Allen, F. W.: Acute Infectious Hepatitis in the Mediterranean Theater, J.A.M.A., 128: 997, 1945.
2. Swift, W. E. Jr.; Gardner, H. T.; Moore, D. J.; Streitfield, F. H., and Havens, W. P. Jr.: Clinical Course of Viral Hepatitis and the Effect of Exercise During Convalescence, J. Med., 8: 614-622, 1950.
3. Best, C. H.: Ferguson, G. C., and Hershey, J. M.: Choline and Liver Fat in Diabetic Dogs, J. Physiol., Vol. 79: 94-102, 1933.
4. Best, C. H., and Channon, H. J.: The Action of Choline and Other Substances in the Prevention and Cure of Fatty Livers, Biochem. Jour., Vol. 29: 2651-2658, 1935.
5. Best, C. H.; Grant, R., and Ridout, J. H.: The Lipotropic Effect of Dietary Protein, J. Physiol., Vol. 86: 337-342, 1936.
6. Leevy, Carroll, M.; Zinke, Myra R.; White, Thomas J., and Gnassi, A. M.: Clinical Observations of the Fatty Liver, Arch. of Int. Med., Vol. 92: p. 527-541, 1953.
7. MacLagan, N. F.: Liver Function Tests (Prothrombin Response to Vitamin K). Disease of the Liver (Text) by Leon Schiff, published by J. B. Lippincott Co., p. 136-137, 1956.
8. Stein, H. B.: The Prothrombin Response to Vitamin K Test in the Differentiation between Intra- and Extra- hepatic Jaundice, South African Jour. of Med. Sc., Vol. 9: p. 111, 1944.
9. Neefe, J. R.: The Treatment of Viral Hepatitis. Diseases of the Liver, by Leon Schiff, J. B. Lippincott Co., p. 322-323, 1956.
10. Rifkin, H.; Marks, L. J.; Hammerman, D. J.; Blumenthal, M. J.; Weiss, A., and Weingarten, B.: Use of Corticotropin and Cortisone in Acute Homologous Serum Hepatitis, Arch. Int. Med., Vol. 89: 32, 1952.
11. Thorn, G. W.; Forsham, P. H.; Frawley, T. F.; Hill, S. R. Jr.; Roche, M.; Staehelin, D., and Wilson, D. L.: Medical Progress; Clinical Usefulness of ACTH and Cortisone, N.E.J.M., Vol. 242: 867, 1950.
12. Davidson, C. S.: The Use of Hypnotics, Analgesics, Sedatives and Anesthetic Agents in Liver Disease. Diseases of the Liver (Text) by Leon Schiff. J. B. Lippincott Co., p. 246-247, 1956.
13. Myers, W. K., and Kiefer, C. S.: Relation of Plasma Proteins to Ascites and Edema in Cirrhosis of the Liver, Arch. Int. Med., Vol. 55: 349, 1935.
14. Bloomfield, A. L.: Therapy of Ascites in Patients with Cirrhosis of the Liver, Arch. Int. Med., 92: 603-605, 1953.
15. Nelson, W. P. III; Rosenbaum, J. D., and Strauss, M. B.: Hyponatremia in Hepatic Cirrhosis Following Paracentesis, J. Clin. Invest., Vol. 30: 738, 1951.
16. Palmer, E. D., and Brick, I. V.: Sources of Upper Gastrointestinal Hemorrhage in Cirrhotic Patients with Esophageal Varices, N.E.J.M., Vol. 248: p. 1057, 1953.
17. Linton, R. R.: The Selection of Patients for Portacaval Shunts, Ann. of Surgery, 134: 433, 1951.
18. Phillips, G. B.; Schwartz, R.; Gabuzda, G. J., and Davidson, C. S.: The Syndrome of Impending Hepatic Coma in Patient with Cirrhosis of the Liver Given Certain Nitrogenous Substances, N.E.J.M., Vol. 247: 239-246, 1952.
19. McDermott, W. V.; Wareham, J., and Riddell, A. G.: Treatment of "Hepatic Coma" with L Glutamic Acid, N.E.J.M., Vol. 253: p. 1093, 1955.
20. Ducci, H., and Katz, R.: Cortisone, ACTH, and Antibiotics in Fulminant Hepatitis, Gastroenterology, Vol. 21: 357, 1952.
21. Sborov, V. M., and Sutherland, D. A.: Fatty Liver Following Aureomycin and Terramycin Therapy in Chronic Liver Disease. Gastroenterology, Vol. 18: p. 598, 1951.

Manuscript Memos

Manuscripts should be submitted in duplicate to the Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month — day of month if weekly — and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The By-laws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The by-laws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.



CASE DISCUSSIONS



CASE DISCUSSIONS FROM THE UNIVERSITY OF LOUISVILLE HOSPITALS A CASE OF MULTIPLE MYELOMA

History and Physical Findings

This 57-year-old white female was referred to the Louisville General hospital for evaluation of severe back pain of nine months duration.

The patient was well and active until nine months prior to admission when she noted severe right upper quadrant pain. The patient was told that she had gall bladder disease and a cholecystectomy was performed without incident. A few weeks following an uneventful recovery from the cholecystectomy the patient noted the sudden onset of pain in the mid back. The pain was severe in intensity and only partially relieved by analgesic agents. Examination revealed some diffuse tenderness throughout the spine without evidence of deformity. X-ray examination revealed diffuse osteoporosis of the thoraco-lumbar spine. The patient had used a brace and received estrogens but both of these measures were of little avail in alleviating the pain.

The past history and family history were essentially noncontributory. Physical examination on admission revealed a well developed, obese white female who appeared chronically ill. The temperature was 98.6, pulse 80, respiration 20, and the blood pressure 115/70 mm. Hg. The significant features on examination were as follows. The patient was in obvious pain and even the slightest motion aggravated the pain. A generalized pallor of the skin and mucous membrane was present. There was diffuse tenderness throughout the thoraco-lumbar spine, and the pressure over the sternum and lateral rib margins produced great discomfort. Neurological examination revealed hyperactive deep reflexes in the lower extremities but there were no pathological reflexes or alterations of the sensory modalities.

Laboratory Findings

Urinalysis revealed a specific gravity of 1015; a four plus proteinuria and on microscopic examination there was an occasional hyalin cast. The red blood count was 2.5 mil.; hemoglobin seven grams; white blood count 6,500 with a normal differential; platelets 115,000. The NPN was 68 milligrams per cent; serum proteins total 12 grams; albumin 3.5 grams; globulin 8.5 grams; calcium 16 milligrams per cent and phosphorus two milligrams per cent. X-ray examination showed a diffuse osteoporosis throughout the thoraco-lumbar spine and osteolytic lesions involving the skull, ribs, and pelvis. A bone marrow specimen aspirated from the sternum showed a heavy infiltration with abnormal, immature plasma cells.

Discussion

T. D. Stevenson, M.D.: The association of severe bone pain with proteinuria and anemia is consistent with plasma cell myeloma. This diagnosis was confirmed by a bone marrow aspiration which showed a diffuse infiltration of the marrow by plasma cells.

Pain in the bones is the most common and characteristic symptom of multiple myeloma and is present in the majority of the patients with this disease. The most prominent site for this pain is the back, followed in order of frequency by the rib cage, hips, legs, shoulders, and arms. The pain is usually severe and progressive. Pathological fractures also occur frequently and may be the initial manifestation of the disease. Fractures involving the vertebral bodies are the most commonly encountered and the fractures usually heal well despite the diffuse involvement of the bones.

In some instances the manifestations of multiple myeloma may be more subtle and obscure. Symptoms and signs of peripheral neuritis may dominate the clinical picture and not all of the neurological complications of multiple myeloma are the result of compression fracture of the spine.

Proteinuria associated with renal insufficiency may be an initial manifestation of multiple myeloma and may occur prior to the onset of the bone pain. Rarely a peculiar form of amyloidosis may be found in association with multiple myeloma and in these individuals the dominant symptoms are those of a chronic arthritis to rheumatoid arthritis.

There are no characteristic or pathognomonic features to be found on examination of the patient with multiple myeloma. Pain on palpation over the spine, sternum, and rib cage may or may not be present. Hepatomegaly is present in approximately 40 per cent of patients and enlargement of the spleen in 20 per cent.

The characteristic features which enable one to suspect and to confirm a diagnosis of a diffuse plasma cell myeloma are found on X-ray examination and examination of the bone marrow. The x-ray picture classically consists of innumerable punched out areas of bone destruction which are diffusely distributed throughout the skeleton. These areas of bone destruction are usually sharply demarcated and are purely osteolytic. The presence of sclerotic changes around the areas of destruction are not usually present in the individual with multiple myeloma. The fact that the bone lesion of multiple myeloma is purely osteolytic aids in differentiation from metastatic carcinoma since the latter is usually associated with sclerosis around the localized bone destruction. In approximately 25 per cent of the individuals with diffuse plasma cell myeloma there are no localized multiple punched out areas but instead the x-ray findings are those of osteoporosis.

Anemia is a common finding in individuals with multiple myeloma. There are usually no significant alterations in the white blood count or in the level of blood platelets. In approximately 10 per cent of the individuals a few plasma cells may be found in the peripheral blood. Auto agglutination of the red cells and an increased sedimentation rate are the result of elevated serum proteins. Examination of the bone marrow is the one single laboratory procedure which enables one to establish the diagnosis of plasma cell myeloma. One usually finds a diffuse infiltration of the bone marrow by immature plasma cells which replace the normal marrow elements. There is usually no difficulty in establishing a diagnosis on the basis of bone marrow findings but the presence of a moderate number of plasma cells is not indicative of multiple myeloma or an incipient stage of that disease. Plasmocytosis of the bone marrow may be found in a variety of diseases, and particularly in association with chronic infections. It should be emphasized, however, that the quantitative and qualitative plasma cell changes found in chronic infections, rheumatoid arthritis, etc. are not as striking as those in multiple myeloma. The presence of a normal bone marrow does not exclude the diagnosis of multiple myeloma, since the accumulations of abnormal plasma cells may be focal in character. I have personally seen and there are described in the literature cases in which multiple bone marrow aspirations from various sites had failed to reveal a diagnostic sample even though focal bone lesions could be demonstrated by x-ray and a biopsy of a characteristic area revealed tissue characteristic of multiple myeloma. Proteinuria in multiple myeloma is usually due to the presence of Bence Jones protein. This is an abnormal protein which is precipitated on heating and redissolves when heated above 95° centigrade. Bence Jones proteinuria is so frequently associated with multiple myeloma that it can be considered almost pathognomonic of the disease. The presence of this abnormal protein results in the formation of casts in the renal tubules and renal insufficiency, a frequent cause of death in the patient with multiple myeloma.

Hypercalcemia is present in approximately 50 per cent of patients with multiple myeloma and the serum proteins, primarily the globulin fraction, are increased in the majority.

The treatment of multiple myeloma is unsatisfactory. The best available agent is urethane which will alleviate pain and reduce the hyperglobulinemia and proteinuria. ACTH and cortisone may be of benefit and x-ray therapy is of value in controlling bone pain.

The book of Nature is that which the physician must read; and to do so he must walk over the leaves.

Paracelsus



EDITORIALS



The Nursing Problem

SINCE World War I there has been an organized lobby for the nursing profession. They first secured their officer status in the armed forces. The nursing organization has increased the requirements for entrance into nurses training. They have improved and raised their standards. Executive positions were occupied by those who had advanced training.

During World War II, nurses did the paper work and the corpsmen did most of the bedside nursing. At the same time, in civilian hospitals the increase in number of patients made it necessary for many of the hospitals to employ nurses aides, practical nurses or technicians.

The time has come for the nursing profession to evaluate its nursing care needs for the public and present some uniform plan for the development and training of two different types of nursing—call them any appropriate name—one for the executive positions and the other to give the practical nursing care.

David M. Cox, M. D.

Dr. Abraham Flexner, Kentuckian

AT THE 1956 commencement exercises the University of Louisville paid honor to Dr. Abraham Flexner by conferring upon him the degree of doctor of science. Dr. Flexner is the recipient of many honorary degrees from leading institutions of learning in our country—two of these being doctor of medicine. Being a Kentuckian, however, he will, in all probability, treasure highly this most recent honor tendered him by our university.

At the age of 89, Dr. Flexner has behind him a life of achievement comparable to that of any scientist that our country has produced. His interest in medical education began in 1908. He was requested by Dr. Henry S. Pritchard, then President of the Carnegie Foundation for the Advancement of Teaching, to make a study of medical education in the United States. Two brothers, Doctors Simon and J. A. Flexner, of Louisville, were physicians but his interest, until that time, had been in teaching in arts and science. Accepting this challenge, Dr. Flexner personally visited and inspected 154 medical schools, carefully tabulating their facilities and methods of training. He acquainted himself also with all of the principal medical schools in Europe, where he traveled in 1910. His report, submitted in 1910, became the basis upon which the entire system of medical education has become the standard for the world.

In a recent book entitled "William H. Welch and the Rise of Modern Medicine," Donald Fleming has described in some detail the process by which these changes were accomplished. Not only was the change at Johns Hopkins University and, subsequently, throughout the country influenced largely by Dr. Flexner's work but his personal contact with the Carnegie and other foundations helped provide the financial aid necessary. He writes that "Abraham Flexner did to death more bad schools in less time than any other man in the history of the world."

After completion of his study of and reports on medical education—which covered a period of four years—Dr. Flexner joined the General Education Board of The Rockefeller Foundation in 1912. Five years later he became secretary of the Board. In 1928 he retired from this position and, two years later, became associated with the Institute for Advanced Studies at Princeton, New Jersey. He secured Dr. Albert Einstein as the institute's first professor. Since his retirement from this work in 1939 he has written and consulted on matters of general

(Continued on Page 725)

ORGANIZATION SECTION

Kentucky Blue Shield Group Plans Seminar September 6

The Kentucky Blue Shield Plan will present a forum Thursday September 6 at the Brown Hotel in Louisville according to W. Vinson Pierce, M.D., Covington, president of the Kentucky Physicians Mutual—the Blue Shield Plan for Kentucky.

The morning session, which begins at 9 AM (Central Daylight Time), will feature a program dealing with how the national Blue Shield Plan works and a discussion of the relative merits of "service plans" and "indemnity plans." Those attending the conference will be guests of Blue Shield at lunch, according to Dr. Pierce. A very interesting question and answer period will be held during the afternoon session.

The names of three of the six speakers who will take part in the program were recently released. They are: Leo Brown, public relations director of the AMA; Walter McBee, executive director of Group Medical and Surgical Service, Dallas, Texas and A. B. Barrett, M.D., chairman of the Insurance Committee of the KSMA.

Invited to the seminar will be all Kentucky directors of the Blue Shield Plan, KSMA officers and councilors, presidents and secretaries of the county medical societies, members of the KSMA insurance committee and members of the KSMA Advisory Committee to Blue Cross.

16 Medical Students Granted Medical Scholarship Loans

Agreements to practice medicine in rural Kentucky have been made by 16 medical students during 1956 as a result of their approval for loans from the Rural Kentucky Medical Scholarship Fund, according to C. C. Howard, M.D., Glasgow, fund chairman. Dr. Howard's report followed a meeting in Louisville, July 10, of the fund's executive committee.

The 1956 loan approvals brought to 35 the number of current medical students being aided by the fund, which was initiated in 1946 by the KSMA and consists of contributions from farm, medical and other groups and individuals. Dr. Howard stated that only five new loan recipients could have been approved this year without $50,000 supplementary funds included in Governor Chandler's 1956-57 budget approved by the 1956 Legislature.

George Caldwell, vice-president of the Louisville Trust Company, as the fund's fiscal agent, reported to the committee that repayment of loans by doctors now in practice is progressing satisfactorily.

New KSMA Members

The following physicians were recently added to the KSMA membership roster:

Fred D. Barlow, M.D., Louisville
Edward C. Frank, M.D., Louisville
Dwight M. Kuhns, M.D., Harlan
Ramon S. Vinas, M.D., Louisville
D. L. Ware, M.D., Cloverport
Ira F. Wheeler, M.D., Prestonsburg

Third Chest Disease Symposium Scheduled For August 29

The third monthly district symposium on "Diseases of the Chest" will be presented at the State TB Hospital, District Five, in London, August 29 at 4 PM (CST).

C. C. Howard, M.D., Glasgow, chairman of the State TB Hospital Commission, will be the before dinner speaker. His talk is entitled "Your Neighbor and Mine."

The scientific session will feature the following program: "Management of the Pneumoconioses and their Complications" by B. E. Jones, M.D.; "Differential Diagnosis of Tuberculosis" by Oren Beatty, M.D.; and "The In-Patient Therapy of Active Tuberculosis" by T. H. Biggs, M.D.

Category 1 credit will be given to members of the KAGP for attendance at the meeting.

Ky. Rural Health Council Begins Plans for '57 National Meet

The Kentucky Rural Health Council met in Louisville, July 10 for consultation with Aubrey Gates, executive director of the Council on Rural Health of the AMA, regarding plans for the Twelfth National Rural Health Conference scheduled for Louisville March 7, 8, and 9, 1957.

The meeting was called to obtain suggestions for the conference program and to discuss ways Kentucky can help in developing the conference. Similar meetings will be held in states bordering Kentucky.

The Conference is sponsored by the AMA in cooperation with agriculture editors, the agriculture extension service, the American Farm Bureau Federation, the Farm Foundation and the National Grange.

Revised Version, Medical Ethics Presented at AMA Meeting

The AMA House of Delegates voted last June at the Annual Meeting in favor of a Reference Committee report which approved a revision of the Principles of Medical Ethics. Final action has been deferred until the Seattle Clinical session to allow for a "thorough study on the part of members of the AMA."

The revised version, prepared by the Council on Constitution and By-laws and endorsed by the Judicial Council, was presented by Louis A. Buie, M.D., chairman of the Council. (Dr. Buie will be a guest scientific speaker at the 1956 KSMA Annual Meeting.)

The 10 proposed sections, an aim to make the Principles more understandable and brief are:

1. The prime objective of the medical profession is to render service to humanity with full respect for both the dignity of man and the rights of patients. Physicians must merit the confidence of those entrusted to their care, rendering to each a full measure of service and devotion.

2. Physicians should strive to improve medical knowledge and skill, and should make available the benefits of their professional attainments.

3. A physician should not base his practice on an exclusive dogma or a sectarian system, nor should he associate voluntarily with those who indulge in such practices.

4. The medical profession must be safeguarded against members deficient in moral character and professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

5. Except in emergencies, a physican may choose whom he will serve. Having undertaken the care of a patient, the physician may not neglect him. Unless he has been discharged, he may discontinue his services only after having given adequate notice. He should not solicit patients.

6. A physician should not dispose of his services under terms or conditions which will interfere with or impair the free and complete exercise of his independent medical judgment and skill or cause deterioration of the quality of medical care.

7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him to his patient.

8. A physician should seek consultation in doubtful or difficult cases, upon request or when it appears that the quality of medical service may be enhanced thereby.

9. Confidences entrusted to physicians or deficiencies observed in the disposition or character of patients, during the course of medical attendance, should not be revealed except as required by law or unless it becomes necessary in order to protect the health and welfare of the individual or the community.

10. The responsibilities of the physician extend not only to the individual but also to society and demand his cooperation and participation in activities which have as their objective the improvement of the health and welfare of the individual and the community.

Alumni of U of L Hospitals Have Reunion June 26

Physicians from all over the United States who took their hospital training at General, Children's or Jewish hospitals returned to Louisville June 26 for the University of Louisville Hospitals Alumni Day. The three hospitals are the medical school's teaching hospitals.

Tours of the Medical Center institutions and Rehabilitation Center started the day-long affair. Afternoon scientific speakers were: William Keller, M.D., Louisville; Edmund Smolik, M.D., St. Louis; Charles Floyd, M.D., Gulfport, Mississippi; O. B. Murphy, M.D., Lexington and Ephraim Roseman M.D., Louisville.

Others on the program were: Dr. Philip Davidson, U of L president; Oscar O. Miller, M.D., Louisville; Gradie Rowntree, M.D., Louisville and J. Murray Kinsman, M.D., dean of the medical school.

UMWA Names Hospital Head

Gordon M. Meade, M.D., former dean of the Graduate School of Medicine at the University of Pennsylvania, has been appointed clinical director of the Miners Memorial Hospital Association. For the past year Dr. Meade has been clinical consultant with headquarters in Washington, D.C. Since January he has served as chief of clinical services at the Williamson Memorial Medical Center in Williamson, West Virginia.

State Aid for Needy Sick Plan to be Studied by Commission

A commission to study the possibility of the State's providing hospital care for indigent sick persons has been etablished by Governor Chandler.

The 12 member group includes representatives from the KSMA, State Hospital Association, Public health and welfare, industry, labor, consumer and rural health organizations. Russell Teague, M.D., State health commissioner, represents the State Department of Health and Keith Smith, M.D., Corbin, the KSMA.

The KSMA sponsored a bill in the 1956 Session of the Legislature providing for the State to put up money toward paying hospital bills of the needy. The bill failed to pass in the closing days of the General Assembly.

154 Attend Annual Seminar at Kentucky Lake June 12

One hundred fifty four physicians registered at the Third Annual Kenlake Seminar on July 12, according to Julian B. Cole, M.D., Henderson, president of the KAGP. The seminar was sponsored by the Kentucky and Tennessee Academies of General Practice.

Fount Richardson, M.D., Chairman of the Board of Directors of the American Academy of General Practice and president of the Arkansas Medical Society, was the guest speaker. He spoke on "The American Academy of General Practice."

Four physicians presented scientific papers at the meeting. They were: F. Tremaine Billings, Jr., Nashville, Tennessee; Henry Turner, Memphis, Tennessee; E. G. Grantham, M.D., Louisville and Allen McAffee, St. Louis, Missouri.

Rufus Alley, M.D., Installed as President of the APS

Rufus Alley, M.D., Lexington, was installed as president of the American Proctologic Society June 9 at the APS 55th Annual Meeting in Detroit. Dr. Alley was treasurer of the Society from 1948 to 1956.

A 1927 graduate of the Medical College of Virginia, Dr. Alley was a surgical assistant at the Lexington Clinic from 1928 to 1932. He served in the US Army from 1941 to 1946.

Dr. Alley, a diplomate of the American Board of Proctology, is a member of the Fayette County Medical Society, the KSMA and the AMA. He is a fellow of the American College of Surgeons and the Philadelphia and Ohio Valley Proctologic Societies which he helped found.

In Lexington, Dr. Alley is head of the department of proctology at the St. Joseph and Good Samaritan Hospitals and is consulting proctologist at Julius Marks Sanatorium and the Veterans Administration Hospital.

Otolaryngologists to Meet

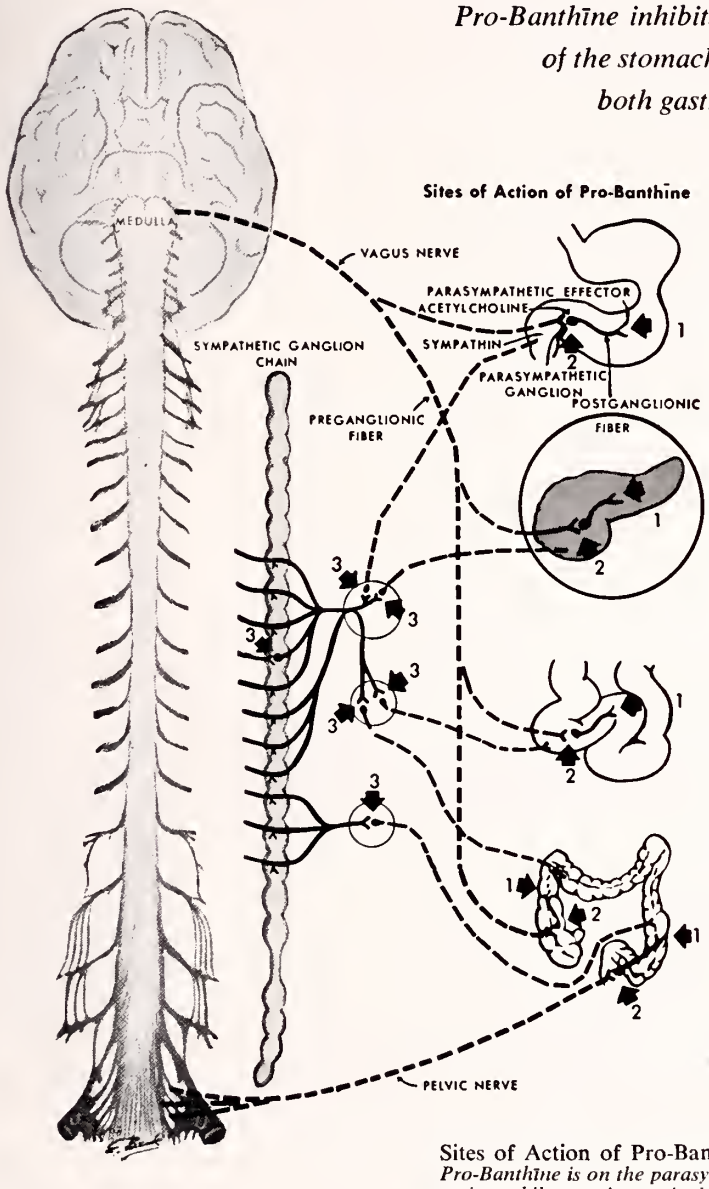
Kentucky physicians planning to attend the Sixth International Congress of Otolaryngology in Washigton, D.C., May 5 to 10, 1957, were recently urged by John W. Harned, M.D., Kentucky Publicity Committee, to make their reservations now.

Dr. Harned also requested that all physicians who had not sent in their check for financial aid for the Congress do so immediately. Checks should be mailed to: Paul Holinger, M.D., 700 N. Michigan Avenue, Chicago, Illinois.

PROVED ANTICHOLINERGIC EFFICIENCY

Pro-Banthīne® Provides Rapid Relief in Acute Pancreatitis

Pro-Banthīne inhibits excessive vagal stimulation of the stomach and pancreas and reduces[1,2] both gastric and pancreatic secretions.



Sites of Action of Pro-Banthīne. *The principal site of action of Pro-Banthīne is on the parasympathetic system where it exerts a dual action while exerting a single and lesser action on the sympathetic system: (1) parasympathetic effector; (2) parasympathetic ganglion; (3) sympathetic ganglion (see arrows).*

With use of the Levin tube and a drug "such as Pro-Banthīne . . . most cases of acute pancreatitis[3] will subside in a few hours, or at the most, in a few days."

Schwartz and Hinton achieved[4] dramatic relief of pain in four of six patients with acute hemorrhagic or edematous pancreatitis within twenty to thirty minutes after giving Pro-Banthīne intramuscularly. A dose of 15 to 30 mg. may be repeated[1] parenterally at intervals of six hours.

Pro-Banthīne bromide (brand of propantheline bromide) also has proved highly effective in the therapy of peptic ulcer, hypertrophic gastritis, diverticulitis, biliary dyskinesia, ileostomies and genitourinary spasm. G. D. Searle & Co., Research in the Service of Medicine.

1. Jones, C. A.: Arch. Int. Med. *96*:332 (Sept.) 1955.
2. Zollinger, R. M.: Postgrad. Med. *15*: 323 (April) 1954.
3. Woodward, E. R.: M. Clin. North America *38*:115 (Jan.) 1954.
4. Schwartz, I. R., and Hinton, J. W.: Personal communication, February, 1955.

SEARLE

Dr. Gaither is Guest Speaker at Joint 12th-15th Meeting

The annual joint meeting of the Twelfth and Fifteenth Councilor Districts was held June 28 at Du Pont Lodge, Cumberland Falls. Ninety persons attended.

Charles B. Stacy, M.D., Pineville, fifteenth district councilor, presided over the entire meeting. Garnett Sweeney, M.D., Liberty, twelfth district councilor, was unable to attend.

The afternoon session featured scientific papers by three Louisville physicians—Rex O. McMorris, Woodford B. Troutman and Hugh Lynn.

Gant Gaither, M.D., Hopkinsville, KSMA president, was the dinner speaker. His talk was entitled "I Dreamed That Greece Might Still Be Free." Thomas Lomasney, M.D., Middlesboro, presented a paper on "Surgery of the Mitral Valve" at the dinner session.

Dr. Hobbs Heads Heart Group

Thomas G. Hobbs, M.D., Lexington, was elected president of the Kentucky Heart Association at its annual meeting June 28 at the Kentucky Hotel in Louisville. Frank Moore, M.D., Bowling Green, was named first vice-president.

William D. Stroud, M.D., professor and head of the department of cardiology at the Graduate School of Medicine at the University of Pennsylvania, was the guest speaker. He spoke on "The Diagnosis and Treatment of Coronary Artery Disease."

Three Physicians Re-Appointed to Medical School Committee

Gant Gaither, M.D., Hopkinsville, KSMA president, recently announced the re-appointment of three members of the Medical School Advisory Committee for three year terms.

Re-appointed were: Clark Bailey, M.D., Harlan; J. T. Gilbert, M.D., Bowling Green and W. Vinson Pierce, M.D., Covington.

Other members of the nine man committee are: Karl Winter, M.D., Louisville, chairman; C. C. Howard, M.D., Glasgow; Thomas O. Meredith, M.D., Harrodsburg; R. O. Joplin, M.D., Louisville; J. Vernon Pace, M.D., Paducah and G. L. Simpson, M.D., Greenville.

Physicians of Fourth District Meet in Bardstown July 19

Physicians and their wives from 13 Kentucky counties attended the 1956 Annual Dinner Meeting of the Fourth Councilor District July 19 at the Bardstown Country Club, according to W. Keith Crume, M.D., councilor.

Gant Gaither, M.D., Hopkinsville, KSMA president, was the guest speaker. His talk was entitled "How Now, Little Man."

Two Louisville physicians, Douglas L. Gillim and Robert S. Dyer presented the scientific section of the meeting.

The audience stood in silent tribute to the late J. I. Greenwell, M.D., New Haven, 1953 AMA Outstanding GP Award Winner.



Trasentine®-Phenobarbital

C I B A
Summit, N. J.

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

2/2228M



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Member of the American Hospital Association and National Association of Private Psychiatric Hospitals

Four modern buildings, separate for men and women Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD,
Hospital Administrator

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M.D., Neuropsychiatrist
Medical Director

T. J. SMITH, M.D., Associate

AMA 1956 PR Institute Planned for August 29-30 in Chicago

Science fairs, legislation, membership indoctrination and tested public relation activities will be a few of the topics under discussion at the 1956 PR Institute to be held August 29-30 in Chicago at the Drake Hotel.

In addition to this, three new films will be premiered—"The Case of the Doubting Doctor", AMA's new membership film; "On Impact", crash injury report produced by the Ford Motor Company in cooperation with the AMA and "Probe", pilot film of a new CBS medical detective series produced in cooperation with the AMA.

Men and women who work with medical society public relation programs, society officers, PR committee chairmen, society lay personnel, auxiliary PR chairmen, and medical school PR personnel are especially urged to attend the institute.

Hospital Commission Organized

A commission on Professional and Hospital Activities to conduct a medical statistical service that will help hospitals simplify medical records and analyze records more effectively was organized recently in Chicago. The commission is sponsored by the American College of Surgeons, American Hospital Association, American College of Physicians and the Southwestern Michigan Hospital Council.

The Commission received a grant of $260,000 from the W. K. Kellogg Foundation, Battle Creek, Michigan to support the program for three years. After this period it is expected the service may be continued on a self-sustaining basis, Paul Hawley, M.D., director of the American College of Surgeons and president of the Commission, said.

125 Physicians Attend Meeting of Sixth District June 27

One hundred twenty-five persons attended the June 27 meeting of the Sixth Councilor District in Glasgow according to L. O. Toomey, M.D., Bowling Green, councilor. Barren County was the host society.

The program, held at the State Tuberculosis Hospital, began with tours through the hospital. C. C. Howard, M.D., Glasgow and Russell Teague, M.D., Louisville were the before-dinner speakers.

A panel discussion on "Chest Diseases", moderated by Russell Starr, M.D., president of the Barren County Medical Society, followed the dinner. Panelists were: Oren Beatty, M.D., Louisville; William S. Burton, M.D., Glasgow; Nathan Lavene, M.D., Louisville; Eugene F. Puess, M.D., Glasgow and Dr. Toomey.

British MD Speaks in Louisville

M. M. Lederman, M.D., London, England, internationally known authority on cancer of the larynx, recently spoke at the Rankin Amphitheatre at General Hospital in Louisville. Dr. Lederman, a physician at the Royal Cancer Hospital, spoke under the auspices of the radiology department of the University of Louisville School of Medicine.

OAGP to Meet Sept. 19-20

The Sixth Annual Scientific Assembly of the Ohio Academy of General Practice will be held at the Franklin County Veterans Memorial Assembly and Exhibition Halls in Columbus, Ohio, September 19-20.

The meeting will be worth 10 hours of post graduate credit for all members of the AAGP, according to Earl D. McCallister, M.D., executive secretary of the academy.

News Items

Henry William Post, M.D., a 1952 graduate of the Tulane University School of Medicine, has become associated with Woodford B. Troutman, M.D., and Ralph M. Denham, M.D., Louisville. Dr. Post who interned and took his residency at the Henry Ford Hospital in Detroit from 1952 to 1956, will limit his practice to cardiology. He is a native of Texas.

John P. Stewart, M.D., Frankfort, has become associated with Thomas P. Leonard, M.D., in the practice of radiology. A native of Frankfort, Dr. Stewart was graduated from the University of Michigan School of Medicine. He interned and took his residency at the University of Michigan Hospital.

C. Clifford Starr, M.D., has opened his office for the practice of general surgery in Louisville. He is associated with J. Duffy Hancock, M.D. A 1951 graduate of the Stritch School of Medicine of Loyola University, Chicago, he served his internship in general surgery at St. Joseph's Infirmary in Louisville.

Billy Adams, M.D., has begun in Louisville a practice limited to pediatrics. A graduate of the University of Louisville Medical School, he served his internship and residency at Children's Hospital in Louisville.

Earl K. Frasher, M.D., a '55 graduate of the University of Cincinnati Medical School, has begun a practice in Louisville. Dr. Frasher interned at St. Anthony Hospital in Louisville.

Edward Warrick, Jr., M.D., has returned from the service and opened an office in Louisville. The '48 University of Louisville Medical School graduate interned at Mercy Hospital in Toledo. He served residencies at the Baptist Hospital and General Hospital in Louisville.

Alvin Morton Churney, M.D., a graduate of the University of Louisville School of Medicine, is practicing pediatrics in Louisville. He served his internship at Kings County Hospital in Brooklyn and his residency at Children's Hospital in Louisville.

Robert Rodes Burham, III, M.D., a graduate of the University of Louisville Medical School, has begun in Louisville a practice limited to surgery. Dr. Burnam was graduated from the University of Louisville Medical School and served both his internship and residency at St. Joseph Infirmary in Louisville.

Bernard W. Barron, M.D., is practicing pediatrics in Louisville. He graduated from the University of Louisville Medical School and served his internship at the United States Public Health Service Hospital in Norfolk, Virginia. He took a residency at Children's Hospital in Louisville.

James Robert Barnes, M.D., has begun a general practice in Louisville. A graduate of the University of Louisville Medical School, he interned at St. Joseph Infirmary in Louisville.

organomercurial diuretics "...permit ingestion of enough salt to make food palatable; without them, many patients would lose their appetites, a consequence of the salt-free diet which has occasionally been known to cause serious malnutrition."*

*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

03156

PERSPIRATION PROOF
Insoles do not crack or curl from perspiration★



- Insole extension and wedge at inner corner of heel where support is most needed.
- The patented arch support construction is guaranteed not to break down.

★ Innersoles guaranteed not to crack or collapse.

- Foot-so-Port lasts designed and the shoe construction engineered with orthopedic advice.
- Conductive Shoes for surgical and operating room personnel. N.B.F.U. specifications.
- We are also the manufacturer of the Gear-Action Shoe designed by noted orthopedic surgeon.
- We make more shoes for polio, club feet and disabled feet than any other shoe manufacturer.

Send for free booklet, "The Preservation of the Function of the Foot Balancing and Synchronizing the Shoe with the Foot."

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.
A Division of Musebeck Shoe Company

the most complete optical service in kentucky

Southern Optical COMPANY

HOME OWNED SINCE 1897

CONTACT LENSES
(Fluidless Lacrilens—Corneal)

ARTIFICIAL EYES
(Custom Plastic—Glass)

4th and Chestnut
334 W. Broadway
LOUISVILLE

W. A. Johnson, M.D., a graduate of the University of Louisville School of Medicine, has started a practice in Owensville. Dr. Johnson interned at the University of Texas Medical Branch Hospital in Galveston.

Le Roy Tunnell, Jr., M.D., a 1955 graduate of the Western Reserve University School of Medicine, has located in Louisville. He interned at the Tripler Hospital in San Francisco.

L. R. Nickell, M.D., formerly a physician in Owensville, has entered the University of Texas Medical Branch Hospital for a three year study in the field of radiology. Dr. Nichell, who interned at Baroness Erlanger Hospital in Chattanooga, went to Owensville in 1953.

Albert Warshauer, M.D., has become associated with the Department of Anesthesiology at the University of Louisville School of Medicine. A 1947 graduate of Washington University School of Medicine, he interned at Jefferson Davis Hospital in Houston.

Carroll Traylor, M.D., has located in Calvert City. Dr. Traylor was graduated from Emory University School of Medicine in 1954 and interned at Fitzsimmons Army Hospital in Denver. He served a residency at Crawford Long Hospital in Atlanta.

John B. Flege, Jr., M.D., a 1954 graduate of the University of Cincinnati School of Medicine has begun a practice in Independence. Dr. Flege interned at Cincinnati General Hospital and served a residency at the University Hospital in Columbus, Ohio.

Dr. Flexner

(Continued from Page 718)

and medical education.

Dr. Morris Flexner, a nephew, continues practice here and is a professor in the Department of Medicine at the Medical School of the University of Louisville.

We rejoice with the family of this renowned educator and scientist in the honor he has brought to our State and City.

Sam A. Overstreet, M.D.

Interns are grossly underpaid, according to the results of a nationwide survey just presented at the Student AMA's Sixth Annual Convention in Chicago. The survey revealed salaries ranging from $75 to $125 a month, with free room and board and an average work week of 85 to 105 hours, no opportunity to earn extra income and no aid from hospital in finding jobs for their wives, although such jobs are available. The group adopted a resolution calling for a listing of hospitals and institutions that meet the SAMA minimum standards established at its convention a year ago; $100 a month, in addition to room, board and laundry. Students could then check this list in choosing internships.



KNOWN and RESPECTED FOR A DECADE...

ATLAS INJECTABLES

Every ATLAS injectable is manufactured in our own new, ultra-modern laboratory under strictest controls. Continued research and testing assures the finest standard injectables as well as distinctive new formulae as they are perfected... Potencies and purity guaranteed, yet a realistic pricing policy makes them readily usable in every case.

Here is our latest Specialty...

RESERPINE **2.5 mg./cc. in 2 cc. Ampules pkgd. 10 ampules per box**

Order today from our representative or direct from our manufacturing laboratories. Complete medical information sent upon request.

ATLAS PHARMACEUTICAL LABORATORIES

13211 Conant Avenue **Detroit, Michigan**

---

specify

LEDERLE

POLIOMYELITIS IMMUNE GLOBULIN

(human)

Lederle

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY Pearl River, New York

Malpractice Prophylaxis

With us
policyholders are in less jeopardy
from malpractice claims and suits
today
than they have been
for the past thirty years

Specialized Service makes our doctor safer

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE Office
Calvin Bimer, Representative
3119 Hewitt Ave.
Tel. Glendale 8-3060
If no answer, call Clay 3636



the Emblems of RELIABLE PROTECTION

We cordially invite your inquiry
for application for membership
which affords protection against
loss of income from accident and
sickness as well as benefits for
hospital expenses for you and
all your dependents.

ALL PREMIUMS COME FROM PHYSICIANS SURGEONS DENTISTS ALL BENEFITS GO TO

$4,500,000 ASSETS
$23,800,000 PAID FOR BENEFITS
SINCE ORGANIZATION

Since 1902

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

EVERY WOMAN WHO SUFFERS IN THE MENOPAUSE DESERVES "PREMARIN"®

widely used natural, oral estrogen

AYERST LABORATORIES
New York, N. Y. • Montreal, Canada
5646

Combined for a

on

resistant

new

METRETON *tablets*

METICORTEN (PREDNISONE) PLUS CHLOR-TRIMETON WITH ASCORBIC ACID

For prompt and effective relief, especially in many resistant allergic disorders, METRETON affords the benefits of two established agents with unexcelled anti-inflammatory, anti-allergic and antipruritic effectiveness. *supported by essential vitamin C*—for stress support and for postulated effect on prolonging steroid action *no better corticosteroid*—original brand of prednisone...minimal electrolyte effects—METICORTEN *no better antihistamine*—unexcelled in potency and freedom from side effects—CHLOR-TRIMETON effective against hay fever, pollen asthma, perennial rhinitis, acute and chronic urticaria, angioneurotic edema, drug reactions, inflammatory and allergic eye disorders, pruritic and contact dermatoses.

formula: Each tablet of METRETON provides 2.5 mg. of METICORTEN (prednisone), 2 mg. of CHLOR-TRIMETON maleate (chlorprophenpyridamine maleate), and 75 mg. ascorbic acid.

supplied: METRETON Tablets, bottles of 30 and 100.

frontal attack

allergies

new

METRETON *nasal spray*

METICORTELONE (PREDNISOLONE) PLUS CHLOR-TRIMETON

quickly clears nasal passages • avoids rebound engorgement and sympathomimetic side effects • safe even for cardiacs, hypertensives, children, pregnant patients •

Composition: Contains 2 mg. (0.2%) METICORTELONE acetate (prednisolone acetate) and 3 mg. (0.3%) of CHLOR-TRIMETON gluconate (chlorprophenpyridamine gluconate) in each cc.

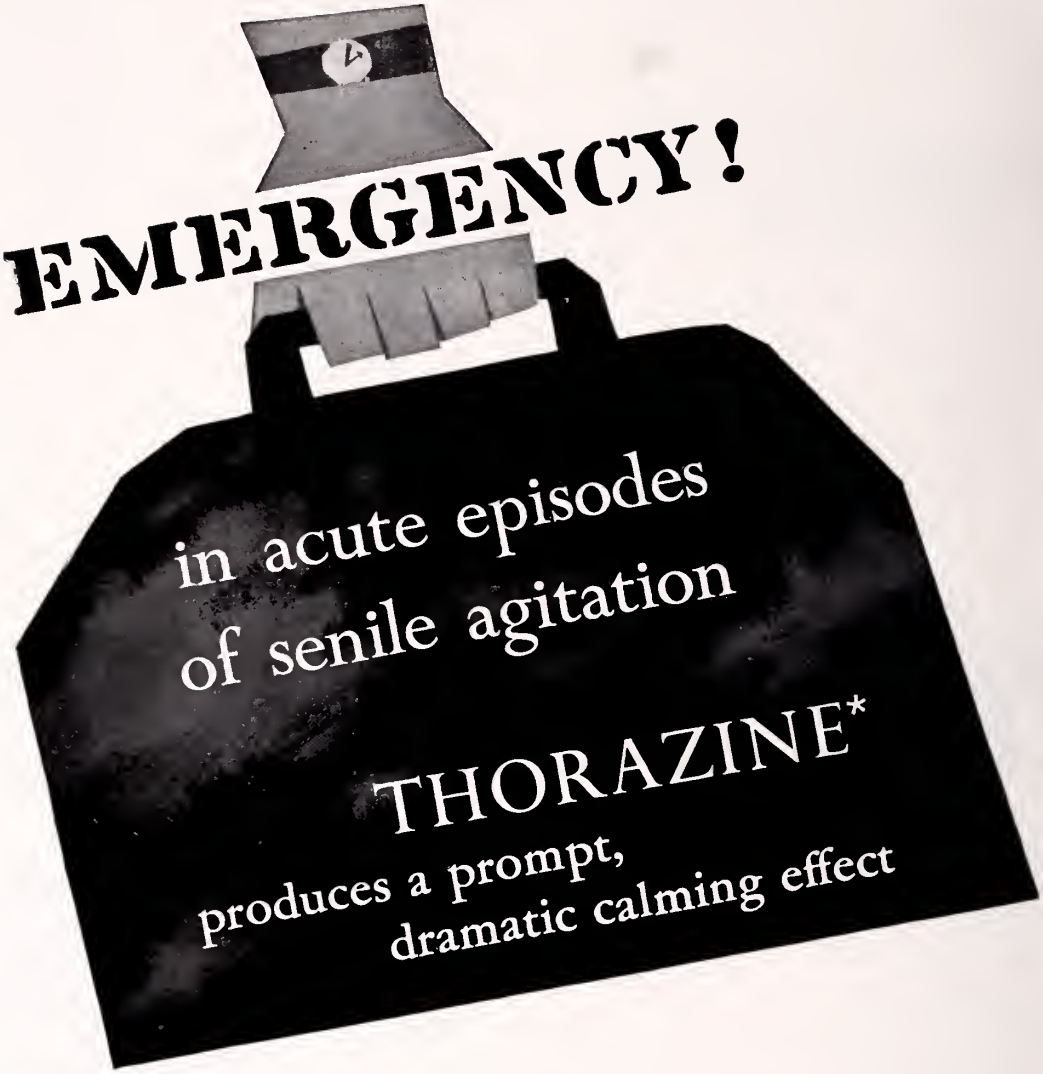
Packaging: 15 cc. plastic "squeeze" bottle, box of 1.

METRETON,* brand of corticoid-antihistamine compound; METICORTEN,* brand of prednisone; METICORTELONE,® brand of prednisolone; CHLOR-TRIMETON,® brand of chlorprophenpyridamine preparations. *T.N.

MT-J-576



Schering



'Thorazine' is available in ampuls, tablets and syrup, as the hydrochloride; and in suppositories, as the base.

'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

always carry 'Thorazine' Ampuls in your bag

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

The Importance of Rescinnamine in

Rauwiloid®

The Original Alseroxylon Fraction of India-Grown Rauwolfia Serpentina, Benth.

The isolation of rescinnamine,[1] another potent alkaloid in Rauwolfia serpentina, has substantiated two important points:

A—It discredits the erroneous opinion that reserpine is *the* sole active principle of Rauwolfia;[2]

B—It helps to define the advantages of Rauwiloid, the alseroxylon fraction of Rauwolfia serpentina, which presents desirable alkaloids[3] of the Rauwolfia plant (among them reserpine and rescinnamine) but is freed from undesirable alkaloids and the dross of the crude root.

Pharmacologic and clinical evaluation has shown rescinnamine to be similar to reserpine in antihypertensive activity, but to be considerably less sedative and much less apt to lead to lethargy and mental depression.[4, 5]

The interaction of reserpine, rescinnamine, and other contained alkaloids may well account for the balanced and desirable clinical behavior of Rauwiloid.

The dosage of Rauwiloid is simple and definite: Merely two 2 mg. tablets at bedtime. For maintenance, one tablet usually suffices.

1. Klohs, M.W.; Draper, M.D., and Keller, F.: Alkaloids of Rauwolfia Serpentina Benth. III. Rescinnamine, a New Hypotensive and Sedative Principle, J. Am. Chem. Soc. 76:2843 (1954).
2. Cronheim, G.; Brown, W.; Cawthorne, J.; Toekes, M.I., and Ungari, J.: Pharmacological Studies with Rescinnamine, a New Alkaloid Isolated from Rauwolfia Serpentina, Proc. Soc. Exper. Biol. & Med. 86:120 (May) 1954.
3. Gourzis, J.T.; Sonnenschein, P.R., and Barden, R.: Alterations in Cardiovascular Responses of the Dog Following Rauwiloid, an Alkaloidal Extract of Rauwolfia Serpentina, Proc. Soc. Exper. Biol. & Med. 85:463 (Mar.) 1954.
4. Hershberger, R.; Hughes, W., and Dennis, E.: Clinical Results in the Treatment of Hypertension with Rescinnamine, Clin. Res. Proc. 3:71 (Feb.) 1955.
5. Smirk, F.H., and McQueen, E.G.: Comparison of Rescinnamine and Reserpine as Hypotensive Agents, Lancet 2:115 (July 16) 1955.

Riker

LOS ANGELES

With us
1925—1 suit filed per 65 policyholders
1935—1 suit filed per 86 policyholders
1945—1 suit filed per 222 policyholders
1955—1 suit filed per 227 policyholders

Relax the best way ... pause for Coke



continuous quality
is quality you trust

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

Tax Returns
Bookkeeping
Delinquent Accounts
(No Commission)
Office Routines
Office Planning
Instructing Personnel
Fees
Partnerships
Hospitals
Clinics
Counselling - Investments
Insurance

ASSOCIATES:

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hubert G. Stiffler
Daniel L. Zeiser
Richard J. Conklin

Available

PROFESSIONAL
BUSINESS
MANAGEMENT

FOR DOCTORS
ONLY

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945
WOodburn 1-1010

141 West McMillan Street
Cincinnati 19, Ohio

I would like to talk with one of your representatives

Name .....

Address .....

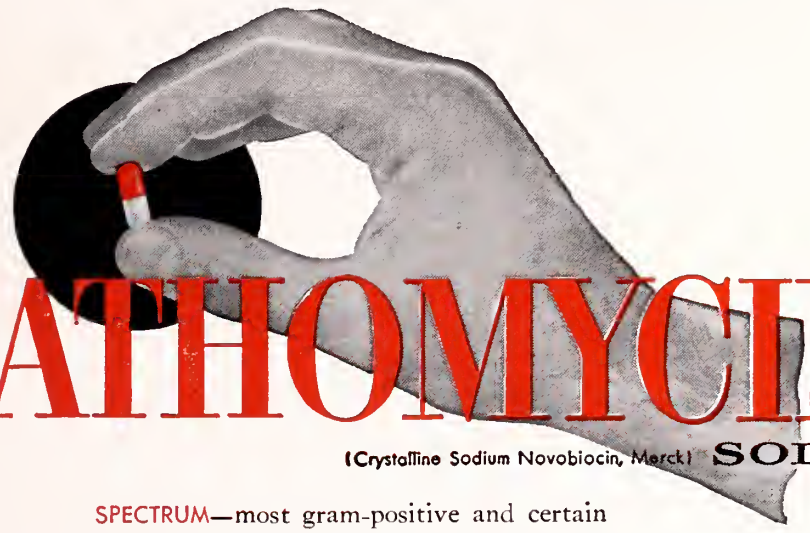
..... Telephone .....

All Services
Completely
Confidential

NOW AVAILABLE...

a unique new antibiotic of major importance

PROVED EFFECTIVE AGAINST SPECIFIC ORGANISMS
(staphylococci and proteus)
RESISTANT TO ALL OTHER ANTIMICROBIAL AGENTS



'CATHOMYCIN'

(Crystalline Sodium Novobiocin, Merck) **SODIUM**

SPECTRUM—most gram-positive and certain gram-negative pathogens.

ACTION—bactericidal in optimum concentration even to resistant strains.

TOXICITY—generally well tolerated. This is more fully discussed in the package insert.

ABSORPTION—oral administration produces high and easily-maintained blood levels.

INDICATIONS—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris;* including strains resistant to all other antibiotics.

DOSAGE—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

'CATHOMYCIN' *is a trademark of Merck & Co., Inc.*

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

"...in patients with moderately severe and severe cardiac failure, neohydrin is the oral diuretic of choice."*

*Moyer, J. H., and others:
J. Chronic Dis. 2:670, 1955.

03056

NEW CASTLE SANITARIUM

Telephone 3621
NEW CASTLE, KY.

For the care of
CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the American Hospitol Assaciotian
Member of the American Assn. of Nursing Homes
Licensed and Approved by the State of Kentucky

SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE
PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS
24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES
New Selectemp Madulated Steom Heat With Filtered Air For Maximum Camfart and Safety
Pratected Thraughaut With Autamatic Fire Detectian and Alarm System

IRA O. WALLACE, Administratar

WAYSIDE HOSPITAL

168 North Broadway
Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

Approved By American Medical Association

Staff

H. Halbert Leet, M.D. — John H. Rompf, M.D.
Carl Wiesel, M.D. — Irving A. Gail, M.D.
Edward L. Houchin, Administrator

Phone: 2-2050

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)

(The Pioneer Postgraduate Medical Institution in America)

SURGERY AND ALLIED SUBJECTS

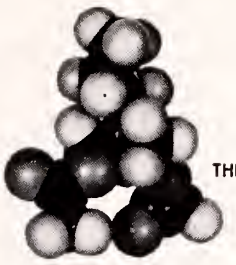
A two months full time combined surgical course comprising general surgery, traumatic surgery, obdominal surgery, gastroenterology, practalagy, gynecological surgery, uralagical surgery. Attendance at lectures, witnessing aperatians, examinatian of patients preaperatively and pastaperatively and fallaw-up in the words postoperatively. Pathalogy, radiology, physical medicine, anesthesia, Cadaver demanstratians in surgical anatomy, thoracic surgery, proctalagy, orthopedics. Operative surgery and aperative gynecalagy an the cadaver. Attendance at departmental and general conferences.

COURSE FOR GENERAL PRACTITIONERS

Intensive full-time instruction in those subjects which are of particular interest to the physician in general practice, consisting of clinics, lectures and demanstratians in the fallawing departments — medicine, pediatrics, cardiology, arthritis, chest diseases, gastraenteralagy, diabetes, allergy, dermatology, neurology, minar surgery, clinical gynecology, proctology, peripheral vascular diseases, fractures, urology, atolaryngology, pathalogy, radiology. The class is expected to attend departmental and general conferences.

For Information about these and other courses Address:

THE DEAN, 345 WEST 50th St., New York 19, N. Y.



THE MILTOWN MOLECULE

A tranquilizer well suited for prolonged therapy

NO ORGANIC CONTRAINDICATIONS

reported to date

- well tolerated, non-addictive, essentially non-toxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

Indications: anxiety and tension states, muscle spasm.

Miltown®

THE ORIGINAL MEPROBAMATE

DISCOVERED AND INTRODUCED by Wallace Laboratories, New Brunswick, N. J.

2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate—U. S. Patent 2,724,720

SUPPLIED: 400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.

Literature and Samples Available on Request

OCULISTS' PRESCRIPTIONS EXCLUSIVELY

MUTH OPTICAL COMPANY

Prescription Opticians

665 S. 4th | Brown Hotel Building | Louisville 2

Clearview

On The Kratzville Road

EVANSVILLE, IND.

TELEPHONE 5-6181

A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.

SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery

ELECTROENCEPHALOGRAPH — CLINICAL LABORATORY—EKG AND BMR EQUIPMENT—STEREOSCOPIC X-RAY — HYDROTHERAPY.

ALBERT J. CREVELLO, M.D.
Diplomate, American Board of Psychiatry & Neurology, Inc.
MEDICAL DIRECTOR

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction

REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION — MEMBER AMERICAN HOSPITAL ASSOCIATION.

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465
334 W. BROADWAY
LOUISVILLE, KENTUCKY

WAbash 6725

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**
( ) **Centralized Bookkeeping** (Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**

SECLUSION MATERNITY



FAIRMOUNT HOSPITAL

FOR UNMARRIED GIRLS
Est. 1909

Private sanitarium with certified obstetrician in charge. Folder fully describing services FREE on request. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

Write for Information

HELEN AMOS
4911 East 27th St.
Kansas City, Mo.
Phone: WA. 3-3577

Offices to be put in condition for rent, located 513 Main Street in Shelbyville (H. C. Craig & Son, Real Estate, 6th St., Shelbyville).

Suitable for two young doctors.

Reasonable Rent—Yearly Lease.

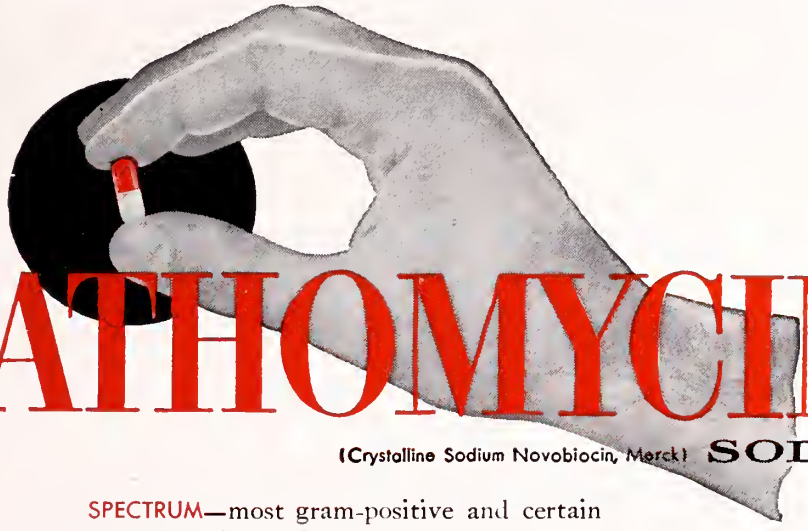
Contact: MRS. ALICE FOREE MASON
1101-15th Street N. W.
Apt. 406
Washington, D. C.

NOW AVAILABLE...

a unique new antibiotic of major importance

PROVED EFFECTIVE AGAINST SPECIFIC ORGANISMS
(staphylococci and proteus)

RESISTANT TO ALL OTHER ANTIMICROBIAL AGENTS



'CATHOMYCIN'

(Crystalline Sodium Novobiocin, Merck) **SODIUM**

SPECTRUM—most gram-positive and certain gram-negative pathogens.

ACTION—bactericidal in optimum concentration even to resistant strains.

TOXICITY—generally well tolerated. This is more fully discussed in the package insert.

ABSORPTION—oral administration produces high and easily-maintained blood levels.

INDICATIONS—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris;* including strains resistant to all other antibiotics.

DOSAGE—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

'CATHOMYCIN' *is a trademark of Merck & Co., Inc.*

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

Adequate Hospitalization for Treatment of Alcoholics

Doctors find the modern facilities and specialized care available at White Cross Hospital meet a vital need.

Affords Sympathetic Atmosphere, Encouraging Personal Attention, Specially Trained Staff

It is generally believed that alcoholism is self-imposed. Often in general hospitals the alcoholic patient is not considered to be "legitimately" sick, which results in the wrong psychological and emotional atmosphere that aggravates the condition. This is why more and more doctors with alcoholic cases where hospitalization is essential are utilizing the facilities at White Cross Hospital, devoted to the treatment of alcoholics exclusively. Here a sympathetic, comfortable and pleasant atmosphere—so essential to rehabilitation—is assured. The White Cross staff, trained in the special problems of the inebriate, is adequate to assure prompt attention at all hours. The White Cross Hospital is under the direction of a competent licensed physician, with five consulting physicians subject to call. Registered nurses and technicians are in charge 24 hours daily.

Safe, Effective White Cross Treatment

A private hospital offering scientific, institutional, medical, psychological, reflex, reduction and other methods for the rehabilitation of consent patients suffering from alcoholism. With the consent of the doctor and patient, the regular White Cross procedure is followed. At your request, your patient remains entirely under your supervision. You may come and go in White Cross Hospital at will, and will find the staff completely cooperative. Your recommendations will be followed to the letter.

All equipment modern with facilities to take care of 50 patients both male and female.



Salem, Va. Hospital

Approved and licensed by the Virginia State Hospital Board, Member American Hospital Association. Located atop beautiful Mt. Regis, in the quiet serene mountains of Virginia—conducive to rest, comfort and rehabilitation.

For information phone or write for booklet
Rates Reasonable

WHITE CROSS HOSPITAL

Five miles west of Roanoke on route No. 11
Salem, Virginia—Phone Salem 4761

Copyright 1955 H.N. Alford, Atlanta, Ga.

CROCKER-FELS COMPANY
SERVING PHYSICIANS AND HOSPITALS SINCE 1882



If you're looking for an unusually attractive examining room suite, unusually serviceable equipment, and special features to make your work easier—you'll find them in Hamilton's Steeltone, shown above. And it's available in an array of decorators' colors: white deluxe, cream white, jade green, washington blue, coral, and silver metallic.

The name Hamilton is synonymous with quality.

The Crocker-Fels Company

624 S. THIRD ST. CLay 8855 LOUISVILLE, KY.

Ask about our liberal financing plan

CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of
mental and nervous disorders, and
addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS—1955-56

Gant Gaither, 109½ East 7th Street, Hopkinsville ..... President
Richard R. Slucher, 2202 Seiger Villa, Louisville ..... President-elect
Clyde C. Sparks, M.D., Mayo Arcade Ashland ..... Immediate Past President
Everett Baker, 408 Brown Bldg., Louisville ..... Vice-President
N. Lewis Bosworth, M.D., 1701 Fincastle Rd., Lexington ..... Vice-President
Howell J. Davis, 330½ Allen, Owensboro ..... Vice-President
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Secretary-Editor Pro tem
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Treasurer
Charles A. Vance, 271 W. Short Street, Lexington ..... Speaker—House of Delegates
E. W. Jackson, 333 Broadway, Paducah ..... Vice Speaker—House of Delegates
J. Vernon Pace, 709-10 Citizen's Bank Bldg., Paducah ..... Chairman of the Council
Delmas M. Clardy, Hopkinsville ..... Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan	1956
Robertson Joplin, Brown Bldg., Louisville (Alternate)	1956
W. Vinson Pierce, 33 E. Seventh St., Covington	1957
Leon Higdon, 333 Broadway, Paducah, (Alternate)	1957

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Building, Paducah	1956
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1958
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Carlisle Morse, 3612 Lexington Road, Louisville	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1958
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1957
Ninth District	J. M. Stevenson, Brookville	1958
Tenth District	J. Farra Van Meter, 183 N. Upper Street, Lexington	1958
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1958
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Charles B. Stacy, Pineville	1957

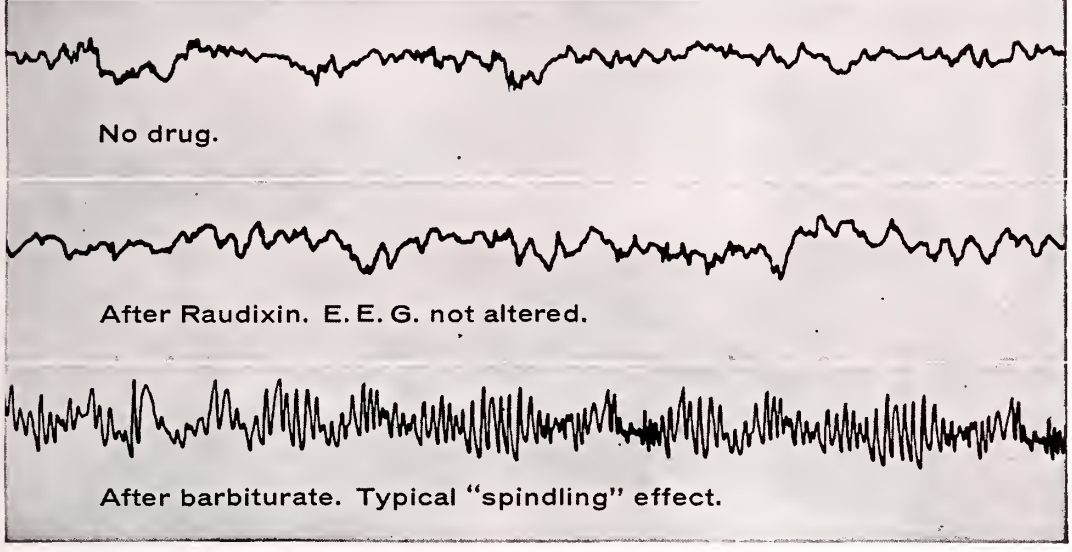
BUYERS GUIDE

JOURNAL OF THE KENTUCKY STATE MEDICAL ASSOCIATION, AUGUST, 1956

Atlas Pharmaceutical Laboratories 726
Ayerst Laboratories 727
Brayten Pharmaceutical Company 665
Brown Hotel 674-675
Brown & Williamson Tobacco Co. 662
Burroughs Welcome & Co. 672
Ciba Pharmaceutical Co. 722
City View Sanitarium 739
Clearview Sanitarium 736
The Coca-Cola Company 732
Corn Products Refining Co. 669
Crocker-Fels Co. 739
Fairmount Hospital 736
Foot-So-Port Shoe Co. 724
The Keeley Institute 736
Lakeside Laboratories 667, 724, 734
Lederle Laboratories 698, 699, 726
Eli Lilly & Company 678
W. R. Long (Insurance Co.) 666
Mrs. Alice Foree Mason (For rent ad) 736
Louisville Medical Dental Business Bureau 736
Medical Protective Co. 726
Merck, Sharp & Dohme 658, 659, 663, 668, 733, 737, 742
Muth Optical Co. 736
New Castle Sanitarium 734
N. Y. Polyclinic Med. Sch. & Hosp. 734
Parke, Davis & Co. 654, 655
Pfizer Laboratories 657, 671
Physicians Casualty Insurance Co. 727
Pleasant Grove Hospital 723
Riker Laboratories 731
Schering Corporation (Insert) .....
Schering Corporation 676, 677, 728, 729
Clayton L. Scroggins & Associates 732
G. D. Searle & Co. 721
Smith, Kline & French 730, 744
Southern Optical Company 725
E. R. Squibb & Co. 741
Wallace Laboratories 735
Wayside Hospital 734
White Cross Hospital 738
Winthrop Laboratories 673
Wyeth, Incorporated 661

WHAT IS THE DIFFERENCE BETWEEN A TRANQUILIZER AND A SEDATIVE?

Comparison of the effect of Raudixin (tranquilizer) and a barbiturate (sedative) on the cortical electroencephalogram



Because barbiturates and other sedatives depress the cerebral cortex, the sedation achieved is accompanied by a reduction in mental alertness.

Raudixin acts in the area of the midbrain and diencephalon, and does not depress the cerebral cortex. Consequently, the tranquilizing (ataractic) effect achieved is generally free of loss of alertness.

RAUDIXIN

Squibb Whole Root Rauwolfia Serpentina

DOSAGE: 100 mg. b.i.d. initially; may be adjusted within a range of 50 mg. to 500 mg. daily. Most patients can be adequately maintained on 100 mg. to 200 mg. per day.

SUPPLY: 50 mg. and 100 mg. tablets; bottles of 100, 1000 and 5000.

SQUIBB *Squibb Quality—the Priceless Ingredient*

'RAUDIXIN'® IS A SQUIBB TRADEMARK

NOW AVAILABLE....

to overcome specific infections that do not respond to any other antibiotic[1,2,3]....

New...



TODAY's resistant pathogens are the tough survivors of a dozen widely-used antibiotics. Certain organisms, notably *Staphylococcus aureus*[4] and susceptible strains of *Proteus vulgaris*, produce infections which have been resistant to *all* clinically useful antibiotics.

To augment your armamentarium against these resistant infections, 'CATHOMYCIN' (Novobiocin, Merck), derived from an organism recently discovered and isolated in the Merck Sharp & Dohme Research Laboratories,[1] is now available.

SPECTRUM—'CATHOMYCIN' [1,2,3,5,6] has also been shown to be active against other organisms including—*D. pneumoniae*, *N. intracellularis*, *S. pyogenes*, *S. viridans* and *H. pertussis*, but clinical evidence must be further evaluated before 'CATHOMYCIN' can be recommended for these pathogens.

ACTION—'CATHOMYCIN' in optimum concentration is bactericidal. Cross-resistance with other antibiotics has not been observed.[7]

TOLERANCE—'CATHOMYCIN' is generally well tolerated by most patients. [5,6,8,9,10,11]

'CATHOMYCIN'

(Crystalline Sodium Novobiocin, Merck) **SODIUM**

ABSORPTION—'CATHOMYCIN' is readily absorbed, [5,6,9] and oral dosage produces significant blood and tissue levels which persist for at least 12 hours.[7]

INDICATIONS: Clinically 'CATHOMYCIN' has proved effective for cellulitis, carbuncles, skin abscesses, wounds, felons, paronychiae, varicose ulcer, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections caused by susceptible strains of *Proteus vulgaris*.[6,7,8,9,10,11,12,13,14] Also, it is of particular value as an adjunct in surgery since staphylococcic infections seem prone to complicate postoperative courses.

DOSAGE: Four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED: 'CATHOMYCIN' Sodium (Crystalline Sodium Novobiocin, Merck) in capsules of 250 mg., bottles of 16.

'CATHOMYCIN' *is a trademark of Merck & Co., Inc.*

REFERENCES:

1. Wallick, H., Harris, D.A., Reagan, M.A., Ruger, M., and Woodruff, H.B., *Antibiotics Annual*, 1955-1956, New York, Medical Encyclopedia, Inc., 1956, pg. 909.
2. Frost, B.M., Valiant, M.E., McClelland, L., Solotorovsky, M., and Cuckler, A.C., *Antibiotics Annual*, 1955-1956, pg. 918.
3. Verwey, W.F., Miller, A.K., and West, M.K., *Antibiotics Annual*, 1955-1956, pg. 924.
4. Kempe, C.H., *Calif. Med.*, **84**:242, (April) 1956.
5. Simon, H.J., McCune, R.M., Dineen, P.A.P., Rogers, D.E., *Antib. Med.*, 2:205, (April) 1956.
6. Lubash, G., Van Der Meulen, J., Berntsen, C., Jr., Tompsett, R., *Antib. Med.*, 2:233, (April) 1956.
7. Lin, F.-K., Cornell, L.L., *Antib. Med.*, 2:268, (April) 1956.
8. Limson, B.M., Romansky, N.J., *Antib. Med.*, 2:277, (April) 1956.
9. Morton, R.F., Prigot, A., Maynard, A. de L., *Antib. Med.*, 2:282, (April) 1956.
10. Nichols, R.L., Finland, M., *Antib. Med.*, 2:241, (April) 1956.
11. Mullins, J.F., Wilson, C.J., *Antib. Med.*, 2:201, (April) 1956.
12. David, N.A., Burgner, P.R., *Antib. Med.*, 2:219, (April) 1956.
13. Martin, W.J., Heilman, F.R., Nichols, D.R., Wellman, W.E., and Geraci, J.E., *Antib. Med.*, 2:258, (April) 1956.
14. Milberg, M.B., Schwartz, R.D., Silverstein, J.N., *Antib. Med.*, 2:286, (April) 1956.

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.



physical sluggishness . . .

decreased mental and emotional control . . .

decreased function in various organ systems

In many of the clinical problems caused by Metabolic Insufficiency you will see *positive improvement within several days.* This is because 'Cytomel' stimulates metabolism at the cellular level.

5 mcg. and 25 mcg. (scored) tablets

Cytomel*

a new agent for treatment of Metabolic Insufficiency

Smith, Kline & French Laboratories, Philadelphia

LT3

*Trademark for L-triiodothyronine, S.K.F.

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION

WILLIAMSON
OCT 31

In this issue:

Hemangiomas

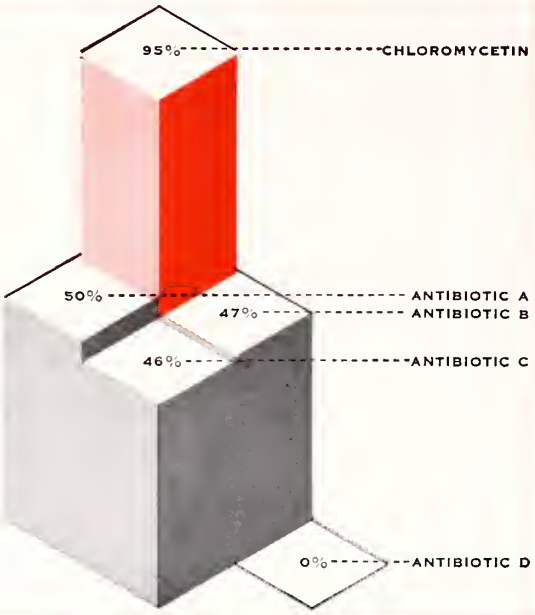
Rheumatoid Arthritis

Evaluation of Tranquilizing Drugs

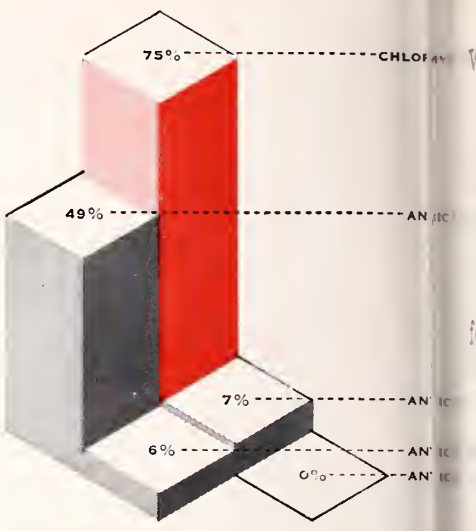
KSMA
Annual Meeting
Sept. 18-20, 1956

VOLUME 54 • NUMBER 9 • SEPTEMBER 1956

SENSITIVITY OF COMMON PATHOGENS TO CHLOROMYCETIN AND FOUR OTHER MAJOR ANTIBIOTIC AGEN

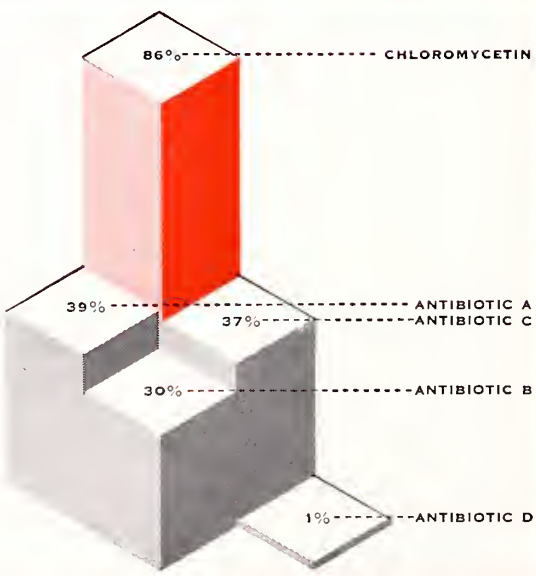


ESCHERICHIA COLI
(148-227 STRAINS)

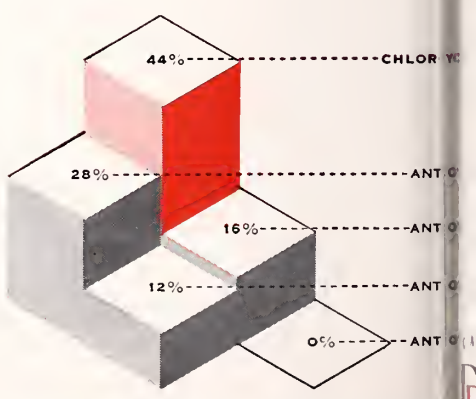


BACILLUS PROTEUS
(63-104 STRAINS)

AEROBACTER AEROGENES
(143-248 STRAINS)



PSEUDOMONAS AERUGINOSA
(39-70 STRAINS)



*This graph, based on *in vit*
is adapted from Horton an

when more than one organism is involved...

Chloromycetin®

for today's problem pathogens

Therapeutic advantages of CHLOROMYCETIN (chloramphenicol, Parke-Davis) are especially appreciated when mixed infections are encountered because it provides highly effective antibiotic action both against gram-negative and against gram-positive pathogens.[1-7] CHLOROMYCETIN also acts against many pathogens which may grow when originally sensitive organisms have been suppressed.[2]

Unlike some antibacterial agents which are specific for one type of organism only, or others to which bacterial resistance readily develops, CHLOROMYCETIN demonstrates continued efficacy against a wide variety of commonly occurring microorganisms: "Sensitivity of many strains of pathogens to chloramphenicol [CHLOROMYCETIN] and limited tendency of these organisms to develop resistance to this antibiotic explain the effectiveness of chloramphenicol where other antibiotics and chemotherapeutic agents have failed."[1]

CHLOROMYCETIN is a potent therapeutic agent, and because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References: (1) Felix, N. S.: *Pediat. Clin. North America* 3:317, 1956. (2) Joron, G. E.; Fowler, A. F.; de Vries, J.; Reid, G., & Mathews, W. H.: *Canad. M. A. J.* 73:956, 1955. (3) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (4) Perry, R. E., Jr.: *North Carolina M. J.* 16:567, 1955. (5) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (6) Murphy, F. D., & Waisbren, B. A., in Murphy, F. D.: Medical Emergencies: Diagnosis and Treatment, ed. 5, Philadelphia, F. A. Davis Company, 1955, p. 557. (7) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305, 1955. (8) Horton, B. F., & Knight, V.: *J. Tennessee M. A.* 48:367, 1955.

PARKE, DAVIS & COMPANY
DETROIT 32, MICHIGAN

63024

The JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR PRO TEM: W. B. TROUTMAN, M. D. MED. EDITORIAL EDITOR: S. A. OVERSTREET, M. D.
MANAGING EDITOR: J. P. SANFORD BOOK REVIEW EDITOR: WALTER S. COE, M. D.
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D. ORGANIZATION EDITOR: BARBARA N. MORGAN
CASE DISCUSSIONS EDITOR: J. C. BELL, M. D. PRINTERS: GIBBS-INMAN, LOUISVILLE

ADVISORY COMMITTEE TO THE EDITOR

Richard J. Rust, M. D. Guy Aud, M. D., Chairman James E. Hix, M. D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1959	Term Expires July 1, 1958	Term Expires July 1, 1957
Robert E. Buten, M.D.	Harry D. Abell, M.D.	Carey C. Barrett, M.D.
Thomas Crume, Jr., M.D.	Henry B. Asman, M.D.	Joe Bush, M.D.
German P. Dillon, Jr., M.D.	Marion F. Beard, M.D.	Allen E. Grimes, M.D.
Pat Imes, M.D.	Rankin Blount, M.D.	Richard F. Grise, M.D.
Stanley Parks, M.D.	Glenn Bryant, M.D.	Billy Keller, M.D.
William Roland, M.D.	William C. Buschemeyer, M.D.	A. J. Miller, M.D.
Maurice Walsh, M.D.	Richard Elliott, M.D.	Robert Reeves, M.D.
James Ward, M.D.	Douglas Scott, M.D.	Charles R. Yancey, M.D.

Published at 620 S. Third Street, Louisville 2, Kentucky

Subscription $8.00 per year Single Copy .80

Contents

SCIENTIFIC ARTICLES

RHEUMATOID ARTHRITIS AND WHAT CAN BE DONE ABOUT IT, John W. Sigler, M.D., Dwight C. Ensign, M.D. 771
SURGICAL MEASURES FOR THE RELIEF OF PAIN, Everett G. Grantham, M.D. 779
HEMANGIOMAS, John B. Floyd, Jr., M.D. 783
EVALUATION OF RESERPINE AND METHYL PHENIDYLACETATE USED SEPARATELY AND IN COMBINATION IN CHRONIC PSYCHOTIC PATIENTS, Harold McPheeters, M.D., Walter Fox, M.D. 785
CASE DISCUSSIONS 792

EDITORIALS

THE METHODIST - EVANGELICAL HOSPITAL 795
WE ARE DOING BETTER 795

ORGANIZATION SECTION

Annual Meeting Plans Announced 797
Dr. Willard Heads UK Med School 797
Movies Scheduled for Annual Meet 798
Eight Members Named Consultants 798
Friends Recognize Dr. Miller's Work 798
12 Scientific Displays Planned 798
SMA Maps 50th Birthday Program 800
Program Sites Given for Annual Meet 800
Educational Expenses are Deductible 801
Annual Meet Exhibitors Thanked 802
S-R Foundation Announces MD Loans 803
SMA Establishes Service Award 803

REGULAR DEPARTMENTS

President's Page 660, In the Books 664, Washington News Digest 670, News Items 724

Second Class Mail privileges authorized at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

For Control of Acute Agitation



- In the acute alcoholic
- In the acute psychotic
- In the drug addict

A potent new agent in chemopsychotherapeutics, SPARINE has demonstrated a marked ability to calm and relax acutely agitated patients.[1,2] Without inducing disabling lethargy or dulling perception, SPARINE ". . . is effective in . . . maintaining these subjects in a quiescent detached state. . . ."[1]

Given intravenously, SPARINE rapidly brings patients under control. Given orally or intramuscularly, it promotes patient accessibility, fosters psychotherapeutic contact, and facilitates over-all management. Parenteral administration of SPARINE is not painful and does not cause tissue necrosis at the site of injection.

For intravenous, intramuscular, or oral administration

1. Fazekas, J.F., et al.: J.A.M.A. **161**:46 (May 5) 1956. 2. Mitchell, E.H.: J.A.M.A. **161**:44 (May 5) 1956.

NEW Potent Ataractic Drug

Sparine*

Hydrochloride

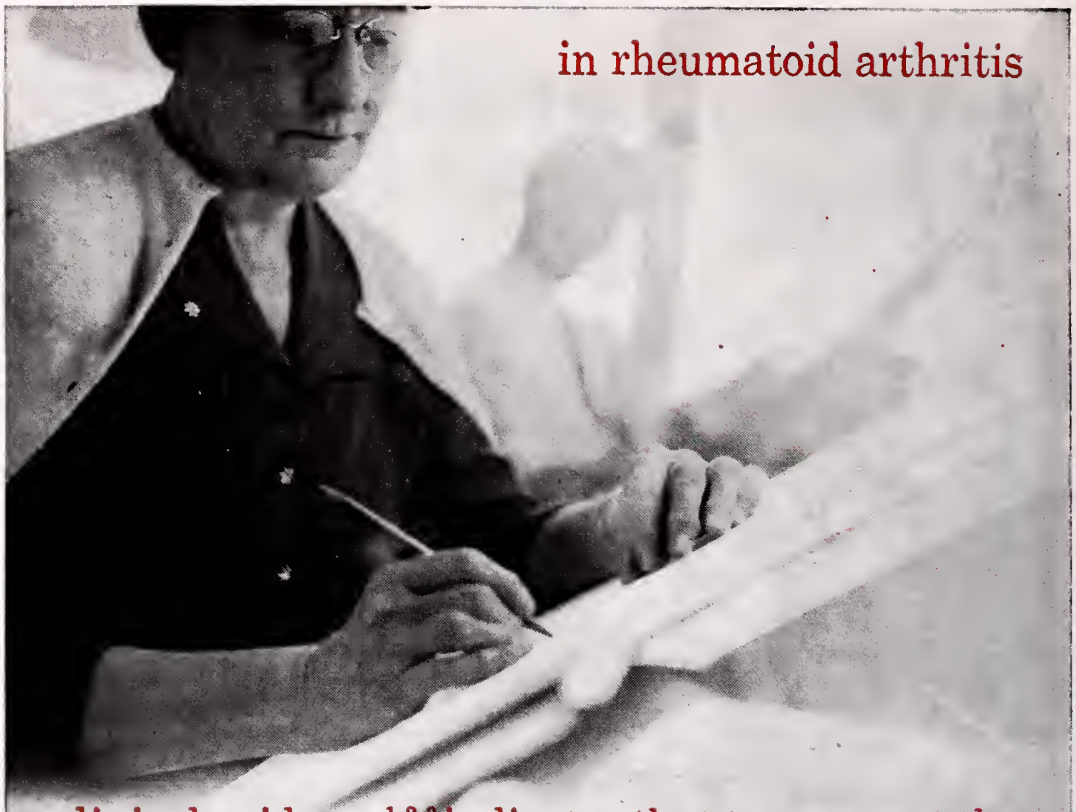
Promazine Hydrochloride

10-(γ-dimethylamino-*n*-propyl)-phenothiazine hydrochloride

*Trademark

Wyeth®

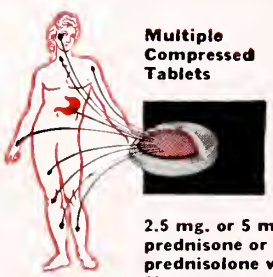
Philadelphia 1, Pa.



clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Prednisolone Buffered)



Multiple Compressed Tablets

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

'Co-Deltra'
(Prednisone Buffered)

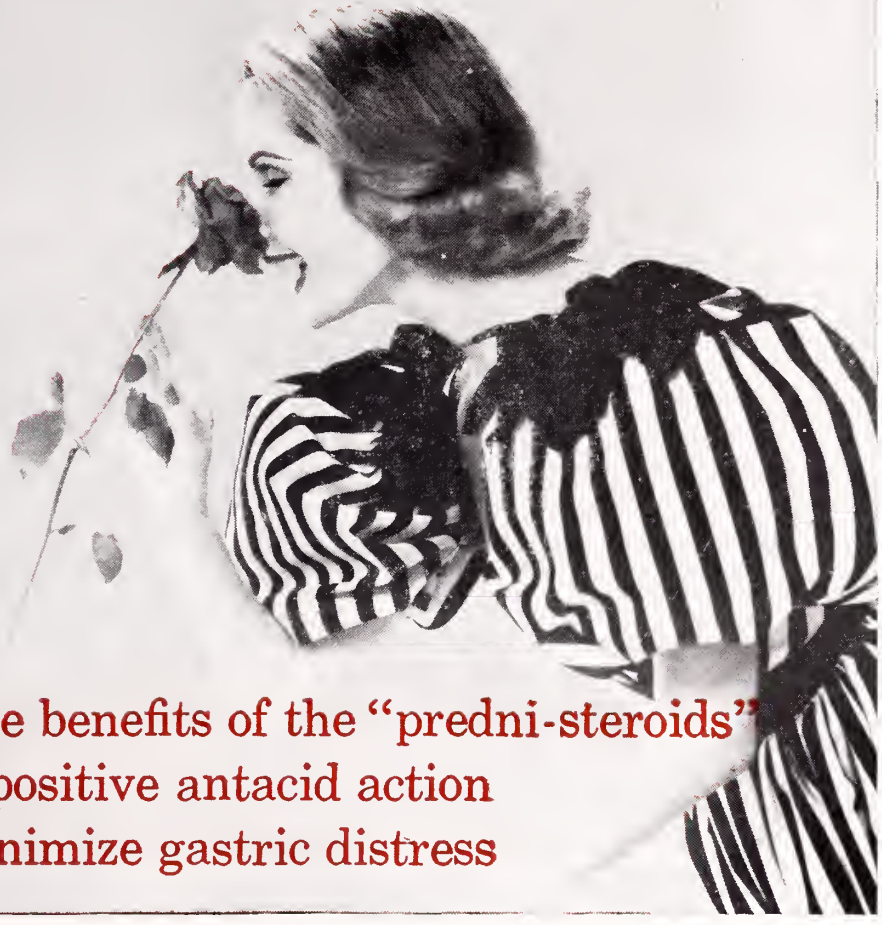
All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are trademarks of* MERCK & CO., INC.

in respiratory allergies



all the benefits of the "predni-steroids"
plus positive antacid action
to minimize gastric distress

ROUTINELY ACHIEVED WITH

'Co-Deltra'
(Prednisone Buffered)



Multiple Compressed Tablets



'Co-Hydeltra'
(Prednisolone Buffered)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* **160**:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* **158**:459 (June 11) 1955.

MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are trademarks of* MERCK & CO., INC.



message from the President

Valete et valete,
atque ave.

September has a calendaric way of coming around once a year. Here it is again. With it your president for the last 12 month period changes his status. He becomes emeritus—the actual term being immediate past president. This adjective 'immediate' is used to soften the impact of his passing. And it does, to some extent.

In slipping into this category, however distinguished, I do so with mingled emotions. None of us is ever able to look back on any year of our lives and feel we have accomplished our real entire objective for the period. Nor can I now as your president in 1956.

But I can tell you how much it means to any physician to have the honor of trying his best to solve the problems as they come up, to anticipate those in the offing and to work hard to leave the Kentucky State Medical Association strong and effective for the safe-guarding the public and private health of the sick people of our Commonwealth.

For this honor, I thank you and say good-bye.

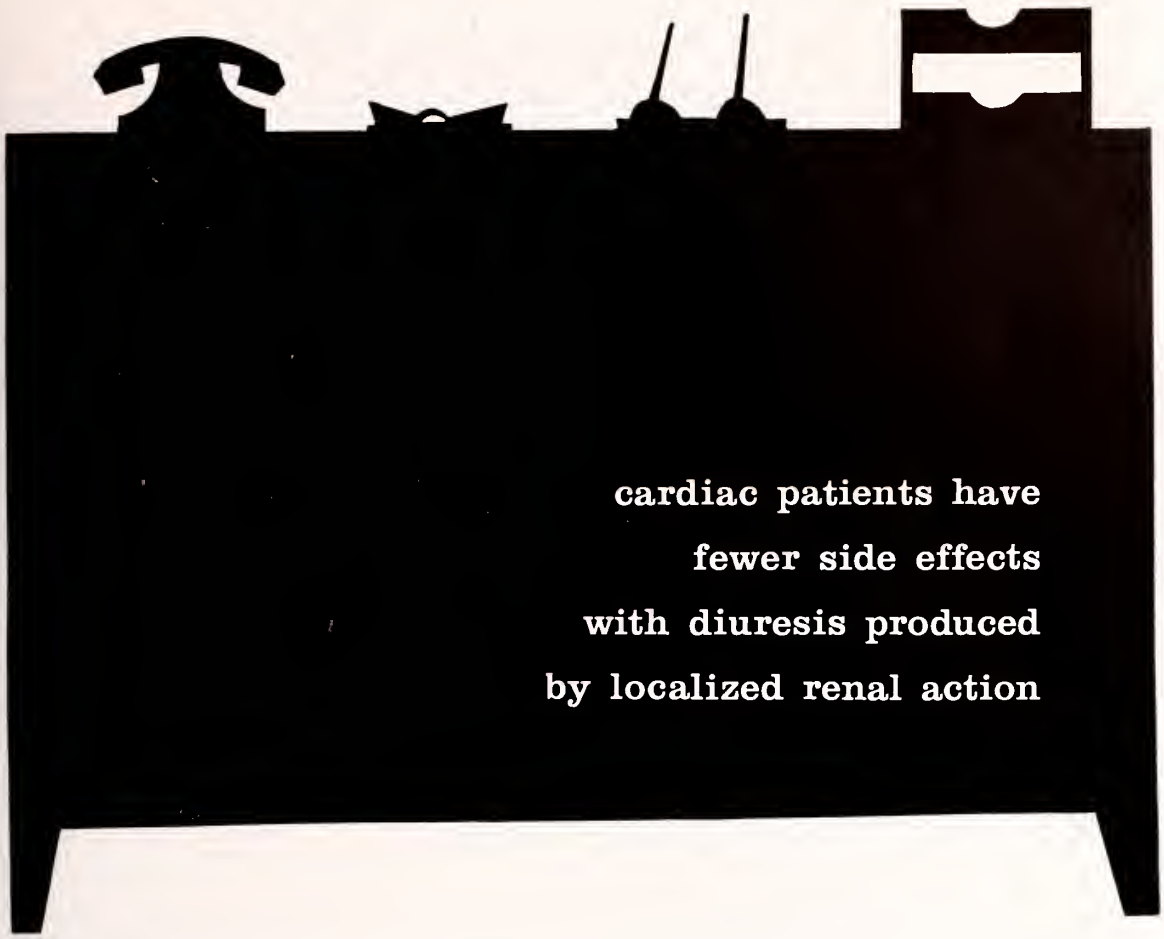
One is heartened in turning the reins over to another driver—(did I say reins—pardon me—I meant the wheel) if he knows him to be competent and safe.

I welcome as your new president Dr. Richard Slucher. He has had long training in the affairs of our association. In his own right he is personable, efficient and has a canny sense of what should be done in difficult situations.

Let us give hearty welcome and warm support.

Gant Gaither

Gant Gaither, M. D.



PATIENTS IN FAILURE NEED AN ORGANOMERCURIAL

When acidosis is the diuretic mechanism, as with the carbonic anhydrase inhibitors and acidifying salts, widespread effects on many organs can be anticipated.
In contrast, the dependable diuresis produced by the organomercurials—resulting from enzyme inhibition localized in the kidney—avoids these extrarenal effects.

TABLET

NEOHYDRIN®

BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure

MERCUHYDRIN® SODIUM
BRAND OF MERALLURIDE INJECTION

LAKESIDE

02656



when bones begin to show signs of change

GYNETONE REPETABS

for osteoporosis of

- menopause
- postmenopause
- senility
- arthritis
- long-term ACTH, cortisone and hydrocortisone therapy

Combined estrogen-androgen therapy with GYNETONE REPETABS stimulates protein synthesis to improve bone-building action and to enhance calcium redeposition* with minimal side effects of either hormone.

*Reifenstein, E. C., Jr., and Albright, F.: J. Clin. Investigation *26*:24, 1947.

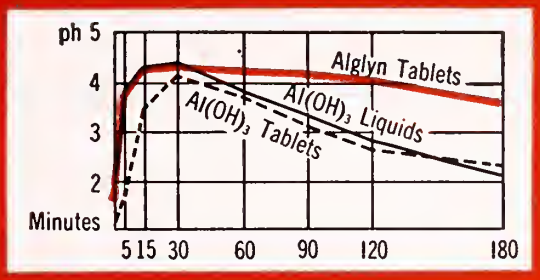
for individualized therapy: two strengths

GYNETONE REPETABS ".02": Ethinyl Estradiol U.S.P. 0.02 mg. plus 5 mg. Methyltestosterone U.S.P.
GYNETONE REPETABS: ".04": Ethinyl Estradiol U.S.P. 0.04 mg. plus 10 mg. Methyltestosterone U.S.P.

GYNETONE,® combined estrogen-androgen.
REPETABS,® Repeat Action Tablets. 61-63-256

SCHERING

Announcing Revision of N.N.R. Monograph for



ALGLYN®

dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayton PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE



IN THE BOOKS



PERINATAL MORTALITY IN NEW YORK CITY: Responsible Factors. A Study of 955 Deaths. The New York Academy of Medicine Committee on Public Health Relations, Subcommittee on Neonatal Mortality; Analyzed and Reported by Schuyler G. Kohl, M.D.; Published for the Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1955; 112 pages; $2.50.

This volume represents the second and final phase of an intensive study of infant mortality in New York City undertaken in 1948 by the Committee on Public Health Relations of the New York Academy of Medicine. The clinical records of 955 babies who died perinatally were studied, and a number of conclusions were drawn from this sample. Thirty-five per cent of the deaths were considered preventable, and the data suggest that the responsibility factors most frequently present were: unavoidable disaster, errors in medical judgment, unsatisfactory pediatric care, errors in medical technique, and faulty prenatal care.

Individual responsibility factors are illustrated by protocols of specific cases. Numerous statistical tables are presented on topics which include type of professional service, the relation of preventability to the mother, analgesia and anesthesia, method of delivery, and demonstrated causes of death.

The study reported in this book was well planned and carefully carried out, and the report itself is presented in impressive detail. The nature of its material prevents the work from being easily readable, so that the volume will undoubtedly be useful primarily as a reference source of statistical information on the important subject of neonatal mortality.

Douglas M. Haynes, M.D.

THE TRUTH ABOUT CANCER: Charles S. Cameron, M.D.; 268 pages; $4.95; Prentice-Hall Inc.

Dr. Cameron has written a textbook on cancer for the layman. It defines and describes briefly the various types of malignant tumors most commonly encountered. The first half of the book consists of several chapters of orientation in cancer causation, epidemiology, diagnosis and research. Misconceptions about cancer and cancer quackery are given special attention.

The last half is devoted to a more detailed description of carcinoma involving the various systems. Clinical descriptions including early and late symptomatology, diagnostic procedure, treatment and prognosis are outlined for each.

The message of the book for the layman is the familiar one of early diagnosis. It stresses the responsibility of the individual to present himself biannually for physical examination. Procedures for self-observation on a monthly basis of skin, mouth, breasts and genitalia are recommended and described.

On the whole the material is presented with scientific fidelity and the use of the eye-catching title is probably justified. Technical language is used skillfully with brief interpretations. Photographs in color add to the realism of the discussion.

The truth about cancer is hardly reassuring in many instances. A case could be made for stressing only the importance of early diagnosis without publicizing the facts which make it clear that even the earliest diagnosis leads to a small salvage rate in carcinoma of the lung and stomach or in melanoma and lymphomata.

However unpleasant the "truth" may be, its presentation to the public in an authentic and unemotional way seems justified. It is only by early diagnosis on the mass scale that salvage rates can be improved in the light of our present knowledge. That the facts will be uncomfortable to some who learn them does not make them less worthwhile to present.

This book will probably find its most numerous readers among those seeking information about the subject of cancer for background purposes. It is not light reading picked up casually for an evening's entertainment.

William A. Blodgett, M.D.

REPRODUCTIVE SYSTEM: Volume 11, The Ciba Collection of Medical Illustrations; by Frank H. Netter, M.D.; 286 pages; $13.00; Ciba Pharmaceutical Products, Inc. Summit, New Jersey.

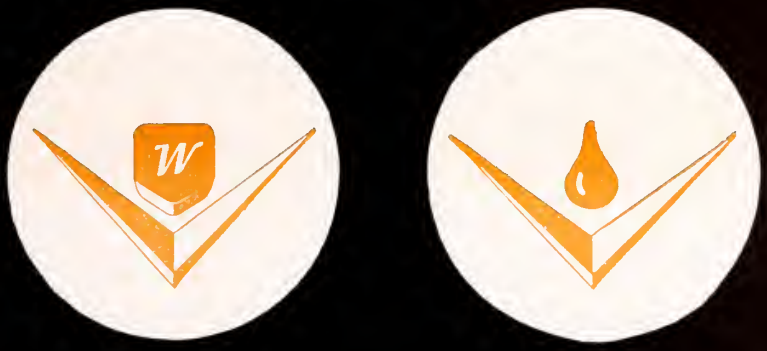
This is a rather complete book covering the reproductive system of both the male and female. Dr. Netter's illustrative drawings are supplemented by comments on each section giving a complete account of the disease or anomaly under discussion. These comments are by recognized authorities on each subject and credit for their discussion is acknowledged in the introduction. The gross pathology is given along with microscopic appearance of the important tissues.

There are 14 sections of the book with one section devoted to embryology of the genital tract, four sections on anatomy and diseases of the male genital tract, six sections on the anatomy and diseases of the female genital tract, one section on pregnancy and its diseases, one section on anatomy and pathology of the breasts, and a final section on pseudohermaphroditism.

A discussion of the cytology of the vagina and cervix and its relation to the diagnosis of early cancer gives this book an up-to-date label.

This is an excellent reference book for the medical student, the obstetrician-gynecologist, and urologist and surgeon who is interested in the anatomy and diseases of the reproductive tract.

Glenn W. Bryant, M.D.



ORAL PENICILLIN FOR *BETTER* AND *MORE CONSISTENT* ABSORPTION

"Because of the better and more consistent absorption of penicillin V from the intestinal tract, it would appear that this type of penicillin is preferable to penicillin G when oral administration is to be used."[1]

1. Martin, W. J., et al.: J.A.M.A. *160*:928 (March 17) 1956.

PEN•VEE•*Oral* and PEN•VEE *Suspension* permit new dependability in oral-penicillin therapy—dependable stability in gastric acid, dependable and optimal absorption in the duodenum. "Not being destroyed by acid in the stomach, as is penicillin G, penicillin V remains available in larger amounts for absorption."[1]

PEN·VEE* *Oral* and *Suspension*

PEN•VEE•*Oral* is Penicillin V, Crystalline (Phenoxymethyl Penicillin)
PEN•VEE *Suspension* is Benzathine Penicillin V Oral Suspension

*Trademark

Wyeth
Philadelphia 1, Pa.

Doctor Disabled

OFFICE EXPENSE CONTINUES

At last, here is the practical solution to this problem - - - an insurance policy to pay your expenses, with the premium eligible as a Tax Deduction.

Latest Tax ruling provides that premiums on Health and Accident insurance are not deductible unless the policy states that it is for the express purpose of meeting business overhead expenses.

Ask your Accountant or Lawyer about this question and then ask us to explain this coverage.

W. R. LONG & ASSOCIATES
1534 Bardstown Road—Louisville, Ky.

Without obligation to me I would like to have more information on your office expense policy. I am in good health and was

born .....
Month Day Year

Name .....

Address .....

Choice location for general practice. A recent death makes office with adjacent home in separate building available. Small town atmosphere. The one other physician in town welcomes help. Practice should be assured immediately. Nine miles from county hospital and about 35 from the Jeffersonville bridge. Ideal for individual who needs immediate practice and yet desires to retain Louisville connections.

Contact: MRS. FRANK GREEN, Rushville, Indiana

Your Support Is
Deserved By The

Diabetes Detection Drive

Sponsored by KSMA
November 11 - 17

Doctors initiated it.—To save lives.

Doctors direct it.—From national to local level.

Doctors gain goodwill because it's public service.

A National Campaign With No Public Fund Raising

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

Meat...

and Its Place in the Diet in Congestive Cardiac Failure

Meat has an appropriate place in the moderate-protein, low-sodium, acid-ash diet advocated in the dietary management of patients with congestive cardiac failure.[1] When extreme sodium restriction is necessary, the meat allowance is regulated accordingly.

Lean meat allows maintenance of a positive nitrogen balance without excessive protein intake, because its amino acids match the quantity and proportions needed for tissue synthesis and repair.[2,3] In the fresh state as purchased it supplies only small amounts of sodium ranging from approximately 50 to 100 mg. per 100 grams. Due to its acid-ash composition (equivalent to 4 to 38 ml. of normal acid per 100 grams of meat) it may facilitate diuresis.[1]

In addition to these important features, meat contributes valuable nutritional factors by virtue of its generous supply of high quality protein, B vitamins, and essential minerals—iron, phosphorus, potassium, and magnesium.

Easy digestibility, a prime requisite of foods eaten by the patient with congestive cardiac failure, is another outstanding quality of meat.

---

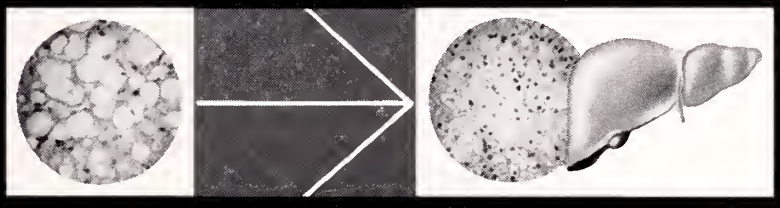
1. Odel, H. M.: Nutrition in Cardiovascular Disease, in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Dietotherapy, Philadelphia, Lea & Febiger, 1955, p. 709.
2. Berg, C. P.: Utilization of Protein, J. Agr. & Food Chem. *3*:575 (July) 1955.
3. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, Williams & Wilkins, 1955, p. 638.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

support...
protect...
help restore
liver normality

in fatty liver
hepatic cirrhosis
hepatitis
alcoholism
obesity
diabetes



methischol

choline • methionine • inositol • liver • vitamin B_{12}

Methischol is a safe, simple form of "liver insurance" which helps to halt and even reverse liver damage in many patients by acting to . . .

prevent the deposition in and aid in the removal of fat from the liver

stimulate the regeneration of new functioning liver cells

lessen the tendency to fibrosis and cirrhosis

generally improve liver function

improve appetite and the nutritional state which are impaired by liver dysfunction

capsules: bottles of 100, 250, 500 and 1000.

syrup: bottles of 16 oz. and 1 gallon.

SAMPLES to the profession on request.

u. s. vitamin corporation

(Arlington-Funk Laboratories, division) • 250 East 43rd Street, New York 17, N. Y.



WASHINGTON NEWS DIGEST



Washington, D. C.—In terms of actual health bills passed and sums of money appropriated, the 84th Congress which ended just a few weeks in advance of party presidential conventions undoubtedly set some records. Measures ranged from the far-reaching program of disability cash payments to a bill for the commissioning of male nurses in the armed services.

In between are a wide variety of measures which, in the opinion of Secretary Folsom, Secretary of Health, Education, and Welfare, gives "promise of immediate and substantial progress on a wide front in the improvement of the nation's health."

Both Mr. Folsom and the President deplored the fact that Congress had not acted on their plan for federal aid to medical schools, but Congress decided this was one of the subjects that needed more study before taking any further action. In addition Mr. Folsom expressed disappointment that nothing had been done on authority for pooling arrangements among small health insurance companies and the long-dormant plan for a health reinsurance fund.

On medical research funds, the administration this session asked for the largest amount of money ever requested in one year. The appropriation finally voted was even larger, some $170 million. On top of this, Congress in its final hours appropriated nearly $80 million to carry out new legislation just passed.

Here are the highlights of major health bills approved by the 84th Congress: Social Security Amendments—Changes in the 21-year-old social security law now include (1) Old Age and Survivors Insurance payments to disabled workers at age 50, paid from a "separate" fund, (2) extension of social security to some 250,000 dentists, lawyers, osteopaths and other self-employed persons, (3) lowering of retirement age for social security purposes for women from 65 to 62, (4) earmarked payments for medical care of public assistance recipients, and (5) increase of payroll deductions by one-half of one per cent and three-eighths of one per cent for the self-employed.

Laboratory Research Facilities—The Hill-Bridges bill for $90 million in construction grants over three years to public and non-profit institutions to erect research facilities started out in the Senate as a bill to aid research in crippling and killing diseases but wound up for research in all "sciences related to health."

Health Amendments Act—The so-called little omnibus health bill provides for federal grants for training of public health specialists, professional nurses qualified for teaching and administrative jobs and for practical nurses—plus a two-year extension beyond next July 1 of the 10-year-old Hill-Burton hospital program, and special projects grants for mental health studies and demonstrations.

Medical Care for Military Dependents—A long-sought goal of the Defense Department was enactment of a permanent program of medical care for dependents of armed services personnel either in military hospitals and clinics or through private sources. It is scheduled to begin early in December.

National Library of Medicine—Another proposal long in the making was the reestablishment of the Armed Forces Medical Library as the National Library of Medicine. For administrative purposes, Congress put it under the Department of HEW, but left up to the 17-man board of regents the selection of site—in all likelihood in the Washington area.

Sickness Survey—Special and continuing surveys on the extent of illness and disability in the U. S., along with medical care being offered have been authorized—the first detailed study of its kind in over 20 years. The work will be done by the Public Health Service.

Water Pollution Control—The PHS is authorized to make grants to states and communities to help in construction of sewage disposal plants, at the rate of $50 million a year for 10 years.

Some other measures signed into law by the President were: establishment of a mental health program for Alaska, budget increases for additional staff for the Food and Drug Administration along with a new headquarters building for modern laboratories, provision of medical care for employees and dependents of the State Department abroad in U. S. military facilities, a $400,000 fund to finance the holding of the World Health Assembly in this country in 1958 (which is the 10th anniversary of the founding of the World Health Organization) and the commissioning in the armed services of osteopaths.

NOTES:

The new surgeon general of the PHS is Leroy E. Burney, M.D., a career officer in the commissioned corps and for 10 years commissioner of health for the state of Indiana. Until his nomination by the President he was deputy chief of the PHS Bureau of State Services. Dr. Burney received his medical degree from Indiana University.

The federal government withdrew from the allocation of the Salk polio-myelitis vaccine just 15 months after the first release of the vaccine, but federal grants to states to help finance inoculation programs continue.

In preparation for a national blood bank directory, the Joint Blood Council with headquarters in Washington launched a nation-wide survey September 1 of all blood banks.



broad-spectrum therapy as good as it tastes!

TETRABON*

BRAND OF TETRACYCLINE **HOMOGENIZED MIXTURE**

125 mg. tetracycline per 5 cc. teaspoonful. Bottles of 2 fl. oz. and 1 pint, packaged ready to use (no reconstitution required). READILY ACCEPTED delightfully different fruit flavor . . . RAPIDLY ABSORBED fine particle dispersion—therapeutic blood levels within one hour . . . QUICKLY EFFECTIVE well-tolerated tetracycline for prompt control of a wide range of infections.

*Trademark

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, N.Y.

Pfizer



save the cigarette for later... Time was you had to wait for a local anesthetic to take hold —you waited, patient waited, nurse waited. **Now, rapid anesthesia....** Blockain* works so fast that clinicians had to describe it as "immediate" and "almost instantaneous." It's practically an understatement to call its action "rapid." **Longer anesthetic duration....** Besides being able to go to work sooner, you can work at an easier pace. Blockain lasts long enough so you can proceed from incision to closure on one injection. You finish up with a neat suture line undistorted by repeated instillations. The patient leaves uncomplaining and comfortable. ☞ *A busy clinician's experience with Blockain in fourteen cases of Colles' fracture:* A single 2-5 cc. injection of Blockain into the hematoma produced anesthesia in an average of 3 minutes 15 seconds. The average duration of these operations, closed reductions, was 25 minutes. Anesthesia persisted beyond the time required for reduction permitting splints to be applied, postreduction X-rays to be taken and the patients sent home feeling comfortable. **BLOCKAIN,** 30 cc., 0.5% (5 mg/cc.). Your office-ideal local anesthetic. For additional information write GEORGE A. **Breon** & COMPANY, 1450 Broadway, New York 18, N. Y.

*BLOCKAIN® BRAND OF PROPOXYCAINE HYDROCHLORIDE BREON.

recognized

as a potent, specific anti-arthritic

established

by over 100 million patient days

substantiated

in more than 700 published reports

BUTAZOLIDIN®

(phenylbutazone GEIGY)

potent, specific anti-arthritic

Based on an impressive background of achievement attained over a period of four years involving both long-term and short-term therapy in all the major forms of arthritis, BUTAZOLIDIN is recognized as one of the most effective anti-arthritic agents currently available.

relieves pain

improves function

resolves inflammation

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before prescribing it.

GEIGY

GEIGY PHARMACEUTICALS, Division of Geigy Chemical Corporation, New York 13, N. Y.

72556

Erythromycin in the treatment of osteomyelitis*

8/3/55

CASE SUMMARY

On 6/2/55, patient, male, age 28, fell on an old fracture and refractured the middle third of the right femur, superimposed on an old osteomyelitis.

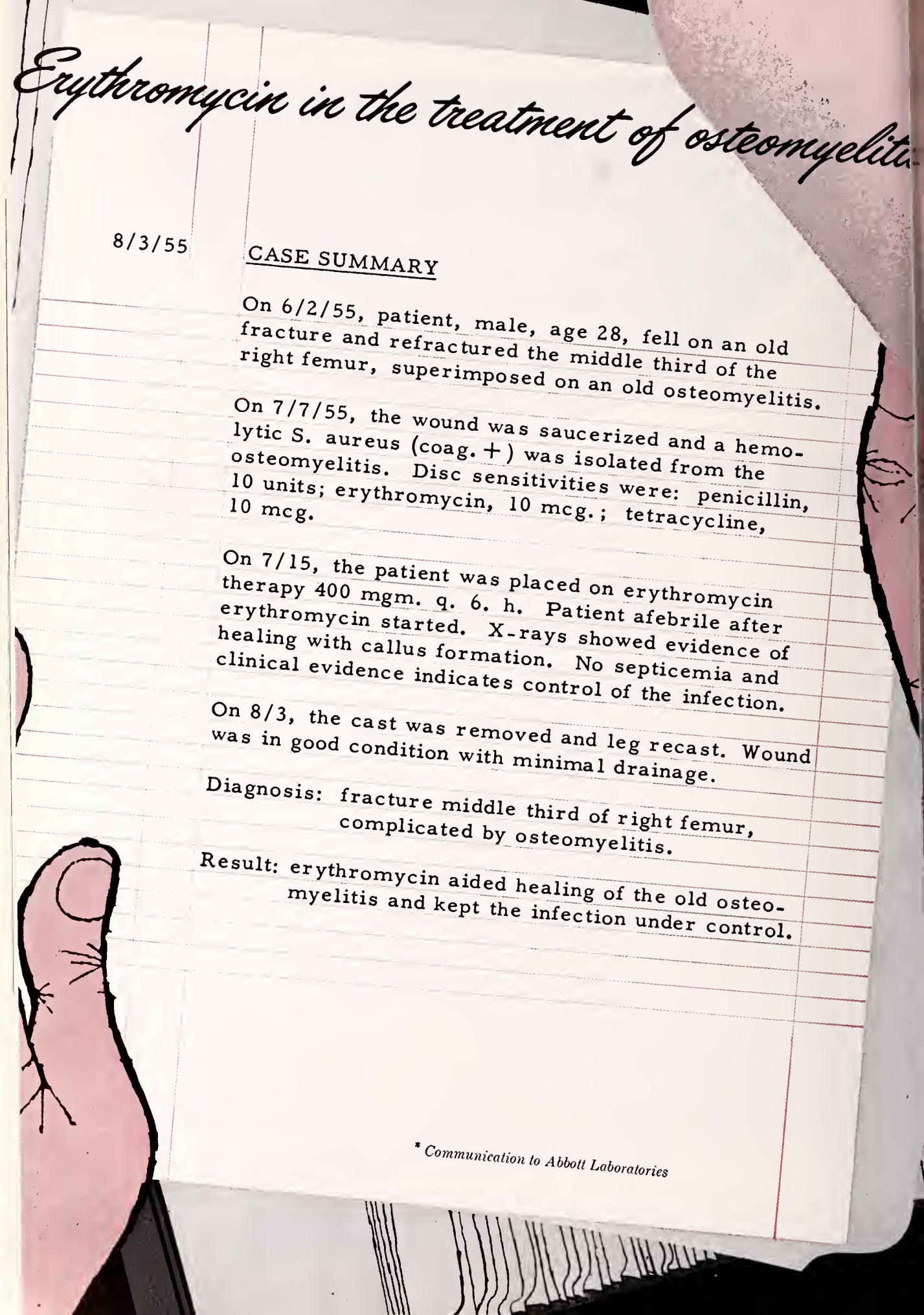
On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

On 8/3, the cast was removed and leg recast. Wound was in good condition with minimal drainage.

Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

Result: erythromycin aided healing of the old osteomyelitis and kept the infection under control.



* *Communication to Abbott Laboratories*

pecific against

occic infections

Specific—because you can actually pinpoint the therapy for coccic infections. That's because most bacterial respiratory infections are caused by staph-, strep-and pneumococci. And these are the very organisms most sensitive to ERYTHROCIN—even when in many cases they resist other antibiotics.

filmtab®

Erythrocin®

(Erythromycin, Abbott)
STEARATE

ith little risk of

erious side effects

Low toxicity—because ERYTHROCIN rarely alters intestinal flora. Thus, your patients seldom get gastroenteral side effects. Or loss of vitamin synthesis in the intestine. Virtually, no allergic reactions, either. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), bottles of 25 and 100. Abbott

filmtab®

Erythrocin®

(Erythromycin, Abbott)
STEARATE

® Filmtab—film-sealed tablets; pat. applied for

609216

new dimensions in the treatment of sever



broadens benefits

- rapid control of allergic sneezing, lacrimation, nasal congestion; relief of pruritus, edema and erythema
- up to 5 times more effective than oral hydrocortisone, milligram for milligram

narrows side effects

- minimizes incidence of fluid and electrolyte disturbance
- dietary regulation usually unnecessary

lengthens established gains

- permits a smoother, undisturbed regimen
- extends and maintains benefits to more patients

ıy fever and other difficult allergies...

METICORTEN*

(PREDNISONE)

for outstanding hormonal control
with minimal electrolyte disturbances

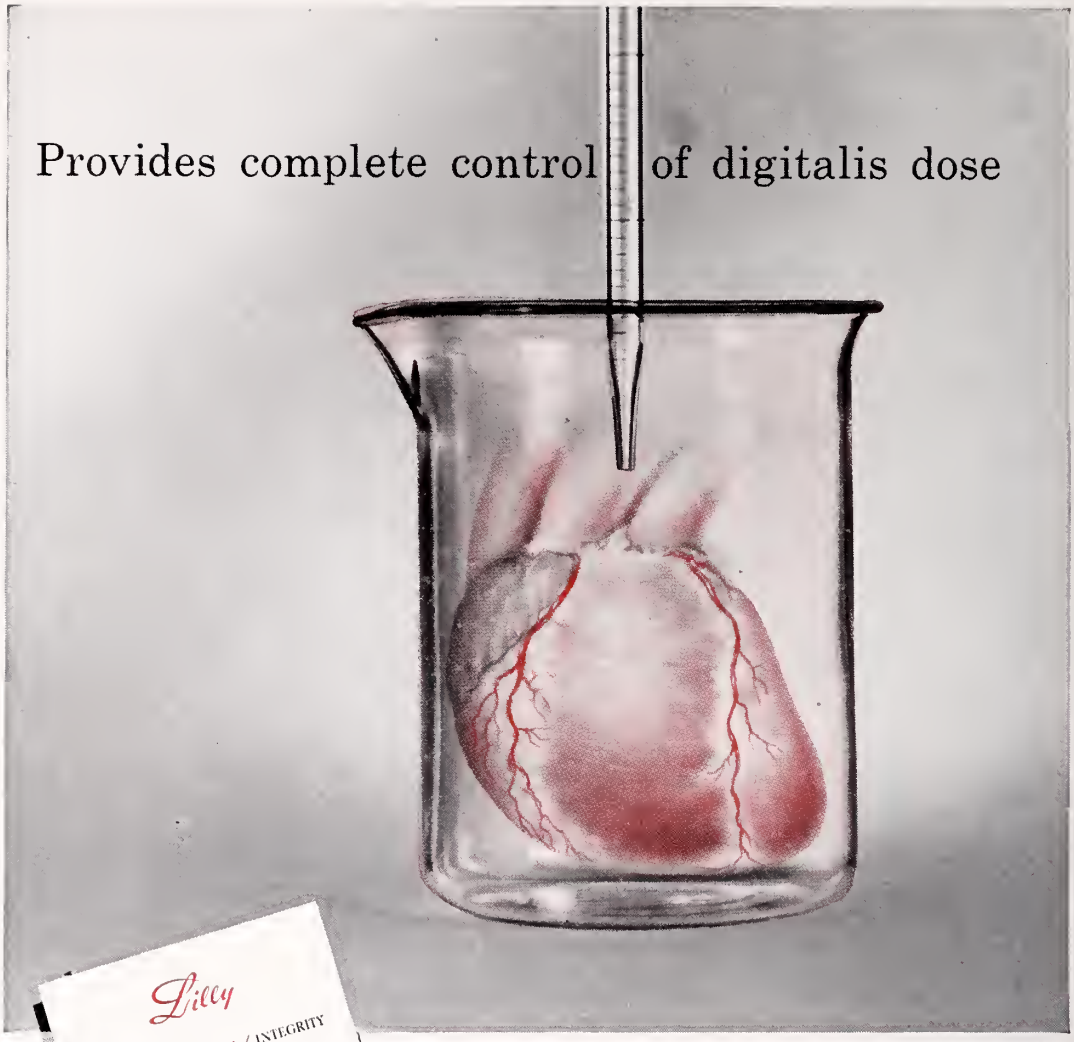
in hay fever and other respiratory allergies,
contact dermatitis and allergic eczemas,
drug and other allergic reactions,
allergic and inflammatory eye disorders



METICORTEN,* brand of prednisone. *T.M.
1, 2.5 and 5 mg. tablets.

MC-J-3086

Schering



'Crystodigin'

(CRYSTALLINE DIGITOXIN, LILLY)

. . . . . permits accurate dosage titration to produce the maximum therapeutic effect

Available in scored tablets of 0.05 mg. (orange), 0.1 mg. (pink), 0.15 mg. (yellow), and 0.2 mg. (white); and in 1-cc. and 10-cc. ampoules, 0.2 mg. per cc.

Since initial digitalization and maintenance dosage must be carefully individualized, 'Crystodigin' fulfills the important requirements of a preferred digitalis. 'Crystodigin' is a crystalline-pure, uniformly potent single glycoside that is completely absorbed in the gastro-intestinal tract. With 'Crystodigin,' the maximum therapeutic effect can be safely determined by dosage titration in increments as small as 0.025 mg.

80TH ANNIVERSARY 1876 · 1956 / ELI LILLY AND COMPANY

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 SEPTEMBER, 1956 NO. 9

RHEUMATOID ARTHRITIS and WHAT CAN BE DONE ABOUT IT*

JOHN W. SIGLER, M.D., DWIGHT C. ENSIGN, M.D.**
Detroit, Michigan

RHEUMATOID ARTHRITIS is a potentially crippling disease of variable and unpredictable course. The etiology is unknown. Since it is prone to develop in early adult life, it presents a serious economic problem for the patient and his family. Too often it is the tendency to prescribe the newest "wonder drug" for all patients presenting musculoskeletal complaints. It is the purpose of this paper not only to plead for early and accurate diagnosis, but also to urge a comprehensive form of treatment with attention to the patient as well as his joints.

DIAGNOSIS

Early Rheumatoid Arthritis

In the early stages of rheumatoid arthritis, perhaps the greatest help for correct diagnosis is a high index of suspicion for this condition. This is especially true for younger individuals complaining of joint distress. Most rheumatologists agree that early diagnosis and prompt treatment will speed remission and minimize deformities.

Rheumatoid arthritis commonly has its onset in young people between 20 and 40 years. It may occur in later life either as a new development or reactivation of a previous attack. Females are more frequently affected than males in a ratio of three to one.

The onset of the disease may be insidious or acute. At times, rheumatoid arthritis follows periods of acute stress, such as infection, severe emotional shock, or other stressful situations. Affected joints usually show symmetrical involvement and symptoms may range from mild stiffness and soreness to obvious swelling, discoloration and immobility. There may be accompanying or preceding fatigue, fever, and weight loss. There is usually progressive joint involvement.

In every patient suspected of having rheumatoid arthritis, a careful evaluation is essential. Physical examination must be complete. Physical findings may reveal pallor, undernutrition, low-grade fever, joint tenderness, local erythema and periarticular swelling, often with effusion (Figure 1). There may be limited joint motion and in more severe cases, a tendency to flexion contractures. As the disease progresses, the joints may show more advanced changes (Figure 2). Lymphadenopathy occurs in about 15 per cent - 20 per cent of cases.

Patients with early rheumatoid arthritis may show a mild anemia and at times an elevation of the white blood cell count. In patients with joint effusion, the synovial fluid often shows an increase in leucocytes of the polymorphonuclear series; the fluid is turbid and tends to clot. The erythrocyte sedimentation rate is usually elevated.

*Presented at Annual Meeting of Kentucky State Medical Association, for Kentucky Chapter, American Academy of General Practice, Louisville, September 29, 1955.

**Based on Exhibit at Scientific Assembly of American Medical Association, Atlantic City, June 6-10, 1955, Exhibit Symposium on Arthritis and Rheumatism prepared for American Rheumatism Association and Arthritis and Rheumatism Foundation. Rheumatoid Arthritis: Dwight C. Ensign, John W. Sigler, Donald F. Hill, and W. Paul Holbrook. J.A.M.A., 157: 1534, April 23, 1955.



Figure 1.



Figure 2.

Differential Diagnosis

Diseases considered in the differential diagnosis are osteoarthritis, gout, rheumatic fever, infectious arthritis, periarticular fibrositis, rheumatoid spondylitis with peripheral joint involvement, collagen diseases (systemic lupus erythematosus, polyarteritis and scleroderma) and palindromic rheumatism.

Osteoarthritis usually occurs in older age groups and patients have none of the systemic symptoms common with rheumatoid arthritis. There is usually a normal erythrocyte sedimentation rate.

Gouty arthritis. Acute gouty arthritis is characteristically monarticular, though polyarticular attacks may occur, especially later in the disease. The onset of acute gouty arthritis is very abrupt, often overnight, with erythema, swelling, marked tenderness and severe pain; the findings are so striking as to suggest cellulitis in some cases. A therapeutic test with colchicine often establishes the diagnosis within 24 hours. The joint manifestations characteristically subside in four to 14 days even without treatment, leaving no residuals until after a succession of acute attacks.

Rheumatic fever is frequently ushered in with migratory joint symptoms; there is usually a history of recent streptococcic infection. The antistreptolysin titer often is positive, whereas it is usually negative in rheumatoid arthritis.

Infectious arthritis should always be suspected in the presence of any acute or chronic infection, particularly gonorrhea and tuberculosis.

Periarticular fibrositis. Symptoms of fibrositis may be confusing and may represent prodromata of rheumatoid arthritis. Such patients should be closely observed for evidence of actual joint involvement.

Shoulder-hand syndrome is a condition which is characterized by pain and swelling of the hand which on superficial consideration may resemble rheumatoid arthritis.

Rheumatoid spondylitis. Peripheral joint involvement in rheumatoid spondylitis is many times indistinguishable from rheumatoid arthritis. Complete spine films with particular attention to the patency of sacro-iliac joints will aid in the diagnosis when back symptoms are a predominating feature.

Collagen diseases. Joint symptoms are frequently seen in systemic (disseminated) lupus erythematosus, polyarteritis, sarcoidosis, dermatomyositis, and scleroderma. In atypical rheumatoid arthritis always suspect these entities. Careful blood evaluations, L. E. tests, skin and muscle biopsies are usually helpful in their differentiation.

Palindromic rheumatism. This term is used to designate a group of patients with frequent attacks of acute joint symptoms which rapidly and spontaneously clear leaving no joint residuals. A high percentage of these patients may

later develop a true picture of rheumatoid arthritis.

Moderate and Advanced Rheumatoid Arthritis

In contradistinction to early rheumatoid arthritis, moderate and advanced disease is usually easily recognized. These stages are characterized by steady progression with exacerbations and remissions of the joint symptoms and findings over several months or years.

When patients in the older age groups are seen with typical rheumatoid arthritis, a careful record of previous joint symptoms may give helpful clues as to the exact onset of the disease. Physical findings in moderate and advanced rheumatoid arthritis show progression of muscle atrophy and limitation or even loss of joint motion (Figure 2) (Figure 3). Rheu-



Figure 3.

matoid nodules appear in 15 per cent - 20 per cent of cases (Figure 4). Subluxations and flexion deformities are present in varying degrees (Figure 5). Osteoporosis, varying degrees of bone destruction, fibrous ankylosis, or, in advanced cases, bony ankylosis may develop (Figure 6) (Figure 7) (Figure 8). Laboratory data are usually not particularly helpful in advanced rheumatoid arthritis, but the anemia



Figure 4.

and elevated erythrocyte sedimentation rate usually persist during the active phases of this disease.

TREATMENT

The treatment of a patient with rheumatoid arthritis must be comprehensive to be effective. Too often the busy practitioner overlooks the older, time-tested principles of general treatment in his enthusiasm over the latest product of the pharmaceutical houses. A substantial number of patients can be controlled by the basic program alone. Without the faithful adherence to the basic program, the supplemental program mentioned later will be relatively ineffective.

Basic Program

The basic program of treatment for rheumatoid arthritis may be considered under the following headings:

Orientation of Patient and Family. The patient and his family must be fully informed as to the nature and course of the disease. It should be stressed that this is a serious and potentially crippling disease whose etiology is



Figure 5.



Figure 6.

still not known, and hence no "cure" can be promised. On the other hand, many cases can be arrested and some degree of help can be given to the majority of patients.

It should be clearly understood that the control of the disease requires the cooperative following of a long-term program, often life-long in fact. It should be further understood that the disease is subject to remissions and exacerbations and that symptoms may be aggravated by stressful situations both physical and emotional. The tendency of patients to "shop" and to try various irregular and irrational treatment fads should be mentioned and discouraged.

The objectives of sound treatment should be



Figure 7.

understood by the patient and family. They may be summarized as follows: To relieve symptoms, improve general health level, prevent crippling so far as possible, arrest the disease, and later to improve function of damaged joints and to educate the patient in adjusting to any uncorrectable residuals.[1]

Symptomatic Therapy. Symptomatic relief is an essential in gaining the confidence and cooperation of the patient. Increased rest, both mental and physical, is important, and often is best obtained by a short period of hospitalization, removing the patient from usual demands. Local rest to acutely painful joints can often be provided by light splints or rest casts.

Salicylates are still the mainstay for medication, for both their analgesic and anti-rheumatic effects. Provided there is no intolerance, aspirin or sodium salicylate should be pushed to full therapeutic effects. Buffered or enteric coated preparations minimize gastric irritation. With nausea or tinnitus, the dosage should be reduced to just below the level where these un-

---

[1]*The booklet "Home Care in Rheumatoid Arthritis," issued by the Medical and Scientific Committee of the Arthritis and Rheumatism Foundation, should be in the hands of every patient with rheumatoid arthritis. It is available for a nominal charge from the Foundation, 23 West 45th Street, New York 36, New York.*

desirable effects occur, but the medication should be continued at a dosage level of 0.6 to 1.0 Gram (10 to 15 grains) four times a day if tolerated. Codeine may be used if night pain interferes with sleep, but its continued use is undesirable.



Figure 8.

General Measures. Since it is well recognized that emotional factors are important in most, if not all, patients with rheumatoid arthritis, thought should be given to correcting or improving personal and environmental stress factors.

There is no specific diet for rheumatoid arthritis, but a balanced diet, high in protein and protective foods is helpful. Since most patients with this disease are undernourished, adequate calories may be provided by supplementary feedings—supplemental vitamins and minerals may be prescribed if there are indications for them, but here again no specificity is implied.

Proper elimination is important, since many patients report increased discomfort during constipation.

The attitude towards focal infection has become more conservative than that which was prevalent 20 years ago. However, when obvious focal infection is present, it should be removed using adequate antibiotic control to minimize dissemination of infection.



Figure 9.

Rest continues to be an important general measure even after the subsidence of the acute symptoms. A definite program suitable for the individual should be outlined. As a rule, frequent brief periods of rest during the day are desirable, with emphasis on the proper joint posture while resting (Figure 9-10). The proper balance between rest and activity must be detailed for each patient.

Local Measures. Daily corrective exercises are of great importance. [1,2] A detailed program must be planned so that all joints are placed through maximum range of motion daily (Figure 11). Exercises may be repeated several



Figure 10.

times daily as tolerated. The local use of dry or moist heat is illustrated in Figures 12-13. Massage may be helpful provided it is well tolerated; massage should be directed to the muscles regional to the involved joints in the presence of acute or subacute joint symptoms and signs.

In many instances the judicious use of intra-

[2] *Holbrook, W. Paul and Hill, Donald F.: Manual of Rheumatic Diseases, Chicago. Year Book Publishers, 1952.*



Figure 11.



Figure 12.

articular hydrocortisone acetate or hydrocortisone tertiary butyl-acetate may provide effective relief of joint pain. Strict aseptic technique must be used in the intra-articular injections to avoid the risk of pyarthrosis.

Every possible effort must be made to prevent the development of contractures, subluxations and ankyloses. It is axiomatic that it is easier to prevent deformities than to correct them. Persistent and well-directed local measures, including the use of splints and rest casts when indicated, are of real value in this regard (Figures 14-15).

Medications. Salicylates (aspirin, sodium salicylate) still constitute the mainstay of the medical treatment of rheumatoid arthritis. Except in those few individuals who are intolerant of them, they should be continued for their anti-rheumatic effect even after the patient has obtained symptomatic relief. Maintenance doses on the order of 0.6 Gram (10 grains) after each meal and at bedtime are well tolerated by most individuals, and are continued



Figure 13.



Figure 14.



Figure 15.

even when the supplemental measures mentioned in a following section become necessary.

Mild sedation with small doses of amobarbital sodium or phenobarbital is helpful in insuring adequate relaxation and rest but is not required by all patients. Narcotics should be avoided. The only exception to this rule is the occasional use of codeine, if necessary, for night pain for short periods during exacerbation of symptoms.

Supplemental Program

The basic program outlined above will be sufficient in perhaps 15 per cent - 20 per cent of patients who are seen in the initial stage of their disease. When the disease is of longer standing, or is observed to be progressing in spite of treatment, the comprehensive basic program should be continued but the following supplemental therapy should be considered.

Special Measures

Chrysotherapy. Gold salts appear to be the best available "stopping mechanism" we have at our disposal at the present time. Many physicians have been frightened by the unfavorable reactions that have occurred with gold salt therapy but chrysotherapy is safe if used with due precaution with the personal supervision of the physician. The useful preparations are organic salts of gold, such as aurothioglucose, given intramuscularly. The initial dose should not exceed five or 10 milligrams; subsequent weekly doses are increased by five milligrams until a dose of 25 milligrams is reached. This is repeated at weekly intervals as long as no symptoms or signs of intolerance develop. Each dose should be preceded by a urinalysis, hemoglobin and white blood count. The physician should personally question the patient prior to each injection, being particularly alert for such things as pruritus, skin rash, stomatitis, purpura or other hemorrhagic phenomena, or any other new development which the patient may have noted. If any question of intolerance is raised by symptoms, physical signs or laboratory evidence, the gold injection is deferred until such findings return to normal.

Milder symptoms of intolerance usually respond to treatment with ACTH or corticosteroids; serious toxicity may require the use of 2, 3-dimercaptopropanol (BAL), but such occurrences are extremely rare if the precautions mentioned above are followed. It is sometimes possible to resume gold injections at a somewhat lower dosage level after minor manifestations of toxicity are controlled.

In the usual case, however, there is no intolerance to weekly intramuscular doses of 25 milligrams, and the treatment is continued at this level, or even at 50 milligrams, intramuscularly each week. In a few cases, evidence of clinical improvement may be apparent when the total cumulative dosage has reached 250 to 300 milligrams, but in many instances such improvement does not become evident until a total of 750 to 1000 milligrams has been administered.

When clinical improvement warrants, the interval between injections is spaced to every two weeks for two or three months, then to every three weeks for a similar period, and ultimately to every four to six weeks. It is considered desirable, however, to continue to give a booster dose of the gold salts intramuscularly at least every six weeks for an indefinite period, and in the event of a reactivation of the disease to return to the program of more frequent injections until remission again occurs.

Chrysotherapy is attended with calculated hazards, which should be frankly explained to the patient and his family. Such hazards must be balanced against the greater risk of omitting therapy which may be instrumental in prompting a remission.

Steroids and Hormones. Corticosteroid preparations (cortisone, hydrocortisone, prednisone, prednisolone) are useful supplements as suppressive agents in patients with actively progressing disease. They are used concomitantly with the program of chrysotherapy, with doses gradually diminishing as gold therapy becomes effective. In many cases they may be necessary for only three to six months.

These preparations are also useful supple-

ments to the basic program in those individuals who do not tolerate gold. Here again, the dose should be carefully controlled, and kept at the lowest level possible to keep the patient reasonably comfortable without attempting complete control of all symptoms. Such steroids are given in divided doses, and total twenty-four hour intake exceeding 37.5 milligrams of cortisone, 30 milligrams of hydrocortisone or 7.5 milligrams of prednisone or prednisolone is undesirable in long term administration.

Some patients may require larger maintenance doses of steroids; however, risks of untoward effects are usually directly proportional to the dose. Particular attention should be paid to the more serious manifestations of hypercortisonism; namely, sodium retention, potassium deficiency, mental depression, ulcerative lesions of the gastro-intestinal tract and osteoporosis. When steroids have been administered for prolonged periods, patients should be warned that should they become involved in any acute stress situation (accident, operation, etc.) they should receive larger doses of cortisone or hydrocortisone orally, or hydrocortisone intravenously in order to counteract the induced adrenal insufficiency. Although sodium retention and potassium deficiency are infrequently encountered with prednisone or prednisolone therapy, ulcerative lesions of the gastro-intestinal tract and osteoporosis are being encountered with increasing frequency. It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum and magnesium hydroxide preparations.

Corticotrophin (ACTH) is useful in controlling acute symptoms in hospitalized patients. The fact that it must be given by injection limits its usefulness in patients who are not hospitalized. Opinion is divided as to the value of weekly injection of a delayed action preparation of ACTH in patients who are on long-term treatment with the corticosteroids, but in some cases it seems to be a desirable adjunct to therapy.

Phenylbutazone. In our experience, with occasional exceptions, phenylbutazone has not been particularly effective in patients with peripheral rheumatoid arthritis. In contradistinction it is effective in rheumatoid spondylitis.

In patients resistant to other anti-rheumatic therapy, a trial of phenylbutazone may be desirable but maintenance therapy is not recommended if the dose required should exceed 200 milligrams to 300 milligrams daily. Here again, the patient must be cautioned regarding possible untoward effects and must be kept under close observation to guard against the development of skin rash anemia, leukopenia, edema or peptic ulcer.

Transfusions. Occasionally whole blood transfusions may be desirable in patients with persistently low hemoglobin levels. However, any hemoglobin below 9 Grams demands careful investigation and a thorough search for causes other than rheumatoid arthritis.

Climate. Many patients do well in warm dry climates. If the patient desires to change climate as a trial measure, and can do so for several months without serious inconvenience, he is encouraged to do so. However, he is told beforehand that he may receive no permanent improvement from the change, and that all other measures of therapy must also be followed in the new location.

Reconstructive Measures

Surgical Correction. One of the fundamental aims of treatment of rheumatoid arthritis is to prevent the development of contractures, subluxations and ankyloses. However, many patients do not present themselves for treatment until after such deformities have developed, and in other patients, deformities may occur in spite of the best treatment currently available.

When the activity of the rheumatoid process is under control, various surgical procedures are available for the correction of persisting deformities. Careful appraisal of such an individual by an orthopedic surgeon may show that the function of one or several important joints can be greatly improved by suitable manipulations, wedging casts, or operations. Any such improvement which can be accomplished is of value not only mechanically in the involved area, but also from the standpoint of the patient's morale in bringing him to a more normal functional condition.

Rehabilitation. The tremendous possibilities of rehabilitation measures in patients who have been damaged by rheumatoid arthritis are still unrealized by the majority of physicians. Unfortunately, the number of centers where such facilities are available is still too small to permit utilization for all patients who deserve

such treatment, but the interested physician who makes a study of the principles of rehabilitation can make a great contribution to his patient's comfort by proper application of such principles. Of fundamental importance in the success of such rehabilitation is the patient's attitude towards his trouble, and his determination to improve his situation. Properly directed physical therapy and occupational therapy, persistently carried out in a home program over months, will often greatly improve the usefulness of badly damaged joints. Many ingenious devices have been developed which permit the more effective use of handicapped joints.[3]

Conclusion

Although the etiology of rheumatoid arthritis is still uncertain, and there is no "cure" for the disease, there is much that can be accomplished with treatment. Such treatment, to be effective, must be based upon an accurate diagnosis, and must be comprehensive and accurately tailored to the needs of the individual patient. Gone are the days when the physician has discharged his obligations to the patient with the too familiar sentence, "You have arthritis, and there's nothing much you can do about it—you might try ———if you want to."

3. "Self-Help Devices for the Arthritic—Rehabilitation Monograph No. 4" by Edward W. Lowman, M.D. Published and distributed by the Institute of Physical Medicine and Rehabilitation, New York University—Bellevue Medical Center, 400 East 34th Street, New York 16, New York.

Fig. 1. Early rheumatoid arthritis. Note fusiform swelling of proximal interphalangeal joint of index finger.
Fig. 2. X-Ray changes in rheumatoid arthritis.
Slight subchondral bone changes in proximal interphalangeal joint of right index finger. Note narrowing but preservation of joint space.
Moderately advanced changes with destruction of articular cartilage and subchondral bone in the proximal interphalangeal joint, left index finger.
Fig. 3. Moderate rheumatoid arthritis showing ulnar deviation of digits. Note swelling in metacarpophalangeal joints and muscle atrophy over dorsum of hand.
Fig. 4. Rheumatoid nodules along ulna. Nodules may appear in any area, usually over bony prominences.
Fig. 5. Subluxation of metacarpophalangeal joints. The proximal interphalangeal joints show compensatory extension deformities. Note rheumatoid nodules over metacarpophalangeal joints and over thumb.
Fig. 6. Advanced rheumatoid arthritis with joint destruction and marked osteoporosis.
Fig. 7. Moderate rheumatoid arthritis with generalized osteoporosis and subchondral bone destruction. Note roughened articular margins.
Fig. 8. Bony ankylosis in a patient with far-advanced rheumatoid arthritis. Note subluxation at metacarpophalangeal joints and marked generalized bone atrophy.
Fig. 9. Incorrect resting positions promote flexion deformities.
Fig. 10. Proper resting positions counteract joint contractures.
Fig. 11. One of many tension exercises to maintain tone in small muscles of hands, thereby counteracting contracture deformities.
Fig. 12. A paraffin bath is a simple way to apply heat to the hands.
Fig. 13. Heat may be applied with infrared bulb or hydrocollator pack.
Fig. 14. A plastic cock-up rest splint offers support to the wrist and maintains optimal functioning position.
Fig. 15. A plaster shell for the knee. This may be used as a resting shell, or when top half is strapped in place, as a leg cylinder.

SURGICAL MEASURES FOR THE RELIEF OF PAIN*

EVERETT G. GRANTHAM, M.D.
Louisville

IT IS not necessary to remind physicians that a prominent aspect of medical care concerns itself with the management of pain. Fortunately, in most instances, the painful aspects of the disorder are eliminated after diagnosis and the institution of proper medical or surgical care. We are all aware, however, that there are times when the pain the patient suffers cannot be cured by direct definitive management of the primary disorder. Not all, but the majority of the patients in this category have incurable cancer. Prominent among the other disorders which may need a pain-relieving operation are:

1. Painful amputation stumps.
2. Destructive arthritis.
3. Angina pectoris.
4. Post-herpetic pain.
5. Phantom limb.
6. Causalgia.
7. Neuralgias of the face and body.
8. Painful scars and neuromas.
9. Various pains of visceral origin.
10. Tabes dorsalis.
11. Tic douloureux.
12. Paraplegia.

Not the least important is a baffling group comprised of those people who complain of intractable pain for which a specific diagnosis cannot be made. Some of these patients have had apparently trivial injuries. Many go from doctor to doctor, sometimes from surgical procedure to surgical procedure without finding any relief of their pain and, in fact, without a specific diagnosis being made. In the end, it is presumed that most of these patients have a psychogenic background for their fixation on pain. Some will refuse psychiatric care; in others, proper effort at psychiatric management does not produce relief, and it is often found

*Presented at the May 19, 1956 meeting of the Kentucky Surgical Society at French Lick, Indiana.

that with the exception of their persistence in complaining of pain for which a cause cannot be found, they have no other evidence of psychiatric disorder.

Whatever the etiological explanation may be for the process producing intractable pain, it is frequently difficult to be certain of the proper operation which is best suited for the individual patient. This applies especially to the group in which a diagnosis cannot be made of a structural disorder which is producing demonstrable pathology. It is often necessary to employ a variety of diagnostic tests, such as peripheral nerve injection, regional novocain blocks, sympathetic blocks and epidural or spinal anesthesias. Occasionally intrathecal alcohol in a small quantity, which will produce temporary paralysis, is worthwhile before resorting to a permanently destructive operation. It is only in the rare instance that alcohol should be used in an effort to produce a long-lasting paralysis of neurological function, because, in most cases, an operative procedure can be done with superior results.

Peripheral Nerve Division

The simplest procedure which can be used for the relief of pain is the division of a peripheral nerve. The usefulness of this operation, however, is exceedingly limited. Most peripheral nerves are mixed, and paralysis of motor function would result from their destruction. As an example, division or avulsion of branches of the trigeminal nerve for painful disorders of the face is an exceedingly useful operation. Relief of pain is of a temporary nature, however, as recovery of function in the nerve invariably takes place. Temporary interruption of peripheal nerves in the lower extremity, by crushing, in the management of ulcerations and early or impending gangrene is considered useful. The posterior tibial, superficial peroneal, the saphenous and sural nerves can be crushed singly or in combination. Division of peripheral nerves carries the risk of subsequent neuroma formation, and a disorder results which may require pain-relieving procedures. In fact, the most common operation on peripheral nerves for the relief of pain is done for the management of painful neuromas. The most successful operation to date for this disorder is the excision of the neuroma and the burial of the central end of the nerve within the substance of a neighboring bone.

Rhizotomy

Rhizotomy is a term used for division of the posterior or sensory root within the central nervous system, at a point between the central nervous system and the ganglion of the nerve. This operation produces a permanent and complete anesthesia in the distribution of the nerve roots. Rhizotomy has a greater field of usefulness than peripheral nerve section. A classical example is the posterior root section for tic douloureux or fifth and ninth nerve neuralgia. In certain malignancies of the head, face and neck, a combination of fifth and ninth rhizotomy and division of upper cervical nerves will anesthetize the pain areas. Rhizotomy is useful for any painful disorder involving a small segment of the body wall, exclusive of the extremities. The operation cannot be used for pain in the extremities, because rhizotomy destroys all forms of sensation, and an anesthetic extremity is a useless extremity. It is rarely used for disorders affecting intra-abdominal organs, because of the extensiveness of the operation which would be needed. For unilateral painful disorders of the body wall, such as scars, tumor of vertebrae and superficial malignancies, it is often an effective procedure, particularly if no more than three or four nerve roots need to be divided to totally incorporate the area involved in the pain. Rhizotomy is also used in angina pectoris and in spastic disorders in patients with permanent paralysis from spinal cord injuries.

Sympathetic Denervation

Temporary interruption of sympathetic function may be all that is necessary in patients with causalgia or Sudeck's atrophy. In patients who have had a long illness with these disorders, permanent sympathetic denervation is needed and is highly effective. In cardiac pain, complete relief can be obtained occasionally by unilateral, and always by bilateral sympathetic denervation, but rhizotomy seems a preferable procedure to sympathectomy, because the bilateral innervation to the heart can be destroyed by one operative procedure. Sympathetic denervation is very useful for disorders of intra-abdominal structures as long as the pathology is confined to the diseased organ. It will not succeed in a disorder such as carcinoma in which extension of the growth to involve somatic structures can be expected. Sympathectomies are employed at times in the management of

painful neuromas and atypical neuralgias of the face and body, but their effectiveness alone, or in combination with other procedures, is debatable and too large a subject to attempt to cover in detail here.

By far the greatest number of patients who have intractable pain will require either a tractotomy or a lobotomy. This includes the majority of all patients with untreatable cancer and most of those in whom a specific diagnosis cannot be made for the cause of their pain. Tractotomy refers to a section of the pain-carrying tracts, the spinothalamic, within the central nervous system, and lobotomy applies to the operation in which a lesion is made in the frontal lobes—which is the area that controls the emotions of pain—and thereby separates this area of the frontal lobe from the thalamus and pain-carrying tracts.

Tractotomy

The classic tractotomy, commonly called cordotomy, is done in the upper dorsal region. This operation has been standard with neurosurgeons since its introduction many years ago. The incision is usually made at the second or third thoracic segmental level. The effective level of the cordotomy, however, will be five or six dermatomes below the site of the incision in the spinal cord. In other words, it produces a sensory level at approximately the xyphoid process or lower, on the opposite side of the body. It is an ideal procedure for pain affecting one hip and lower extremity. Disorders of the lower abdomen or pelvic structures, which receive their innervation from both sides of the spinal cord, will not be relieved by unilateral cordotomy. In such disorders, a bilateral procedure is necessary. The chief disadvantage of cordotomy is that, when it has to be done bilaterally, there is some danger of producing weakness in the lower extremities, and perhaps more important, there is frequently a disturbance of bladder and bowel function, although in most instances this paralysis is temporary. A practical point for consideration of the possible effectiveness of any tractotomy is the length of time during which pain has been a problem. Unfortunately, many patients, especially those with inoperable cancer, have had long periods of medical care before any such neurosurgical procedure is given consideration. In the meantime, they have often been given increasingly large doses of narcotics, and the problem is highly complicated by this situation. When the operation is done in the face of this addiction, one too often discovers that from the objective point of view the operation is a success, that is, the patient has lost sensation to pain in the lower half of his body, yet he continues to have a complaint of pain, either in the original area or perhaps in a new area of the body, and complains of this pain to such a degree that to him, at least, continued use of narcotics is justified. If a patient comes to surgery for the relief of pain before the narcotic problem develops, the opposite is true; the relief of his discomfort is very gratifying.

Cervical tractotomy is now being employed with greater frequency. In the past this operation was looked upon as dangerous, primarily because the lesion into the spinal cord was made near or above the nerve supply to the diaphragm, and respiratory failure was feared. In addition, there was the theoretical danger of paralysis of the arm as well as the leg, since the lesion is above the supply to the brachial plexus. A cervical cordotomy provides a means of relieving pain in the chest, shoulder and arm. In the past, patients with pain in these areas were often neglected, because there was no suitable surgical procedure to offer them. Rhizotomy could not be used because the resulting anesthesia produced a useless extremity. It has now been clearly demonstrated by several studies, in different clinics, that cervical cordotomy is a highly effective operation, in many respects superior to a similar operation done in the dorsal spine. The difference in the segmental level in which the lesion is made in the spinal cord and the effective dermatome level in the body will vary by only one or two segments. As we have noted, if the section is made in the spinothalamic tract at the second dorsal segment, the effective dermatome level will subsequently drop to the seventh or eighth dorsal, and sometimes even lower. This is not true in the cervical area. If the lesion is made in the second cervical segment, one can expect an effective cordotomy at least as high as the fourth, and often at the third cervical dermatome level. Whether at the third or the second, the lesion is high enough that the entire arm is made analgesic and not anesthetic, as would happen with a rhizotomy and, consequently, disorders which affect the chest, supraclavicular area, shoulder and arm are effectively relieved

by tractotomy at the second cervical spinal segment. Furthermore, bilateral cordotomies can be done at this level with no higher incidence of death or damage to motor or sphincteric function than when done in the dorsal level. There is no doubt that cervical cordotomies will become more popular as information about them is disseminated. This procedure is also used effectively when the painful process involves the neck and the suboccipital region. With analgesia produced by the cordotomy to include the fourth dermatome level, which includes the shoulder, the effective level can be raised by a rhizotomy of the first, second and third cervical nerve roots. These nerves are divided through the same incision which is made for the cervical cordotomy. In such a patient, the anesthesia will extend into the suboccipital region. Tractotomy has been performed in the medulla, pons, and mesencephalon, but carries a high mortality and is not recommended.

Lobotomy

Lobotomy has not been used as extensively in the treatment of pain perhaps as might have occurred had it not been for the information disseminated to the public concerning the early use of this procedure for psychiatric disorders. A very radical operation was then done and widespread reports have appeared through lay and scientific literature of the terrific destruction to personality and intellectual capacity which has resulted from this operation. The truth of the matter is that a more selective or limited lobotomy has been used by nearly every one who has advised the operation for the relief of pain, and these more specific or limited procedures do not carry the damage to personality and mental functions which the old radical operation did. At the same time, it must be admitted that there is less enthusiasm for its use for pain than there was originally. It is no panacea, but it has been discovered that for certain patients it is very useful, and at the same time much has been learned about the type of patient in whom it cannot be expected to be successful. The patient who has a high threshold for pain, who is not agitated and anxious over his pathology, and who is not requiring narcotics will receive little benefit from the procedure; in fact, it should not be done on such an individual. On the contrary, the patient who is highly emotional, nervous, tense, anxious, fears death or the complications which his disorder is possibly going to produce is the ideal patient for the use of lobotomy to control his pain as well as his emotions. There is no question but that the patient's emotional reaction to his disorder can be favorably affected, and the operation is even more useful in the group with this type of emotional makeup, in whom narcotic addiction has become established.

The management of pain for the patient with cancer is never quite satisfactory because of the very nature of his continuing illness and ultimate, often early, death. It is difficult, therefore, to evaluate the effectiveness of any operation which is used for pain relief. The results in non-fatal disorders are more gratifying and easier to assess. Since our experience with lobotomy began six years ago, pain-relieving operations in these years were reviewed, primarily to compare the results of patients operated upon by cordotomy or lobotomy. During this period, 262 patients have been treated with pain-relieving operations. Tractotomy was performed on 61 patients; 14 patients had bilateral operations. Effective relief of pain was accomplished in 60 per cent of those who could be followed. In six that did not have a good result following cordotomy, subsequent lobotomy was performed with good results in three. Five cordotomies were done in the cervical region, with good results in the four patients who survived the operation. It was somewhat of a surprise to find that the results in 52 patients who had lobotomy were roughly the same as the patients treated by tractotomy, that is, approximately 60 per cent had satisfactory relief of pain. While these results are approximately the same as published results in other series, the percentage of good results following both of these operations should be higher, and it is felt that the percentage can be improved by proper selection of the operation suitable for each patient. This applies particularly to the patient who is suffering with cancer. The results of cordotomy can be further improved by greater care in technical detail, to be certain that the incision in the spinal cord is made at a depth that will insure a permanent high level of analgesia. Many of the poor results have been due to the subsequent drops in the analgesic level, and this can be blamed on inadequate incisions. In addition, it has been our experience, as it has with others, that poor

results not infrequently follow the use of a unilateral cordotomy, when a bilateral cordotomy would probably have been successful. This generally results from misinterpretation of the distribution of pain in disorders involving pelvic structures.

Conclusion

In conclusion, it has been my purpose to present in brief form some current thoughts on operations which are useful in the management of intractable pain. With proper attention to the selection of the most suitable operation for the individual patient and careful attention to the technical considerations, relief of intolerable pain can be given to the majority of patients.

HEMANGIOMAS*

JOHN B. FLOYD, JR., M.D.
Lexington

HEMANGIOMAS are tumor-like abnormalities, composed of blood vessels. In origin, most are probably congenital, the result of incomplete coalescence of embryonal vascular spaces as the early heart begins to form discrete channels through mesenchymal buds and cords. Thus, sequestration of embryonal mesenchymal buds and cords takes place. The cell masses have a certain power of irregular and unrestrained growth. Solid buds extended into adjacent tissues, canalize and establish a connection with the parent vessel. The organoid tumors serving no useful function may or may not have direct connection with the general circulation.[1] These lesions account for 90 per cent of the angiomas, lymphangiomas and hygromas accounting for the other 10 per cent. Two of every three are found in females.[2] Most are noticeable at birth, and usually enlarge to some degree. The true hemangiomas as such are neoplastic in origin. Ewing considered most of these processes to be neoplastic.[3] Ewing's tumor of the bone, Kaposi's sarcoma, and metastasizing hemangioepitheliomas are the prominent malignant examples of this rare group.

Classification

Schafer points out that the distinct categories hemangiomas fall into serve little purpose clinically. He feels that port wine stains and strawberry birth marks, which commonly occur on the scalp, face and neck, should properly be recognized as congenital telangiectasias and not considered angiomas. These usually remain stationary throughout life. However, if any growth occurs a "wait and see if it regresses" policy should not be adopted. Treatment for control of the vascular spaces should be started.

Hemangiomas are generally classified into two types, cavernous and capillary.[4] Watson and McCarthy from a treatment standpoint listed an additional six groups, based on comparative clinical, pathological, and therapeutic considerations:

1. The angioblastic or hypertrophic type. This is found chiefly in the skin and is a solid raised purplish red lesion which is not compressible. On section, it consists of a mass of endothelial cells with obliterated vessel lumens. It is locally aggresive, and prone to recur. It has been mistaken for a hemangio-sarcoma. It is rare.
2. The cirsoid type of hemangioma is also relatively rare. It appears as a bulky, soft bluish-red pulsating mass of dilated vessels. They are noted chiefly in adults and around the head and neck.
3. The diffuse systemic hemangioma usually affects a whole extremity with visible and palpable evidence of tissue hypertrophy due to the abnormal blood supply. These are thought to be different from that picture seen due to the presence of multiple minute congenital arterio-venous fistulas.[5]
4. The very rare so-called metastasizing hemangiomas which are sarcomas.
5. The nevus vinous or port wine stain presents on section a very narrow superficial zone of scattered dilated vessels, lined with flattened adult endothelium. The proliferative mass characteristic of a real hemangioma is lacking.
6. Hereditary hemorrhagic telangiectasa, or Rendu-Osler-Weber Disease, the diag-

*Presented at a county society meeting, West Liberty, Kentucky, February 22, 1956.

nosis of which requires three findings, repeated hemorrhages, telangiectatic lesions, and a familial history.

Freezing and Injection

Since differentiation between cavernous and capillary hemangiomas is difficult at best,[4] therapeutic principles are based on controlling the tumor without injury to or disturbance of the growth of the surrounding parts, with the least possible scarring.[6] Thus, the decision is made in each case as to the best way to accomplish it. Carbon dioxide snow therapy is satisfactory for superficial capillary lesions and for clearing residual mottled areas remaining after injection therapy.[2, 7] Suitably shaped blocks are held firmly in contact with the skin for seven to 10 seconds. If contact is held longer than 12 seconds, superficial ulceration results. The freeze injures the endothelial cells and induces thrombosis.

Injection treatment is a popular, practical, and useful means of controlling most of the lesions, except for the very superficial type and for huge inaccessible tumors. Five per cent Sodium Morrhuate in doses of one-fourth cc. to three or four cc. has been the most commonly used sclerosing agent, and has been the usual subject of reports. In the past 10 years Sodium Sotradechol (one per cent and three per cent) solutions have developed as probably a more useful drug in doses of 0.1 cc. to 0.5 cc. Sotradechal also has the advantage over Morrhuate of being less antigenic and more miscible. The small doses of the weaker (one per cent) solutions are used in insterstitial sclerosing, while larger doses of the stronger (three per cent) solutions are used when blood can be aspirated from cavernous spaces. Superficial sloughing of the skin may be avoided with infiltration of the area with one per cent Procaine as an adjunct to minimal repeated doses. Procaine prevents intense vasospasm. Compression dressings to cavernous spaces tend to promote thrombosis.

Radiation Therapy

Radiation therapy is both external and interstitial in application. Watson and McCarthy[2] felt that external radiation in the form of brass plaques containing radon capsules had its chief use in the treatment of capillary hemangiomas which are too thick for carbon dioxide snow therapy, and also superficial small cavernous hemangiomas which resist injection therapy. While they felt that the end results in the use of high and low voltage roentgen rays were disappointing, they stated that high voltage roentgen ray therapy seemed to be ideal for the treatment of bone hemangiomas. It also yielded satisfactory and successful end results in the treatment of hemangiomas of the joints and synovia. Brown and Fryer[6] feel that heavy surface radiation is best indicated for those rapidly growing, destructive, red arterial hemangiomas, which threaten necrosis by out-growing their blood supply. This mode of treatment with high dosage is used with the knowledge that a chronic irradiation lesion of the skin will develop. This is removed and the area is resurfaced with a graft.[6] This is an evidence of extending radiation therapy possibilities with the use of skin grafts.[8]

Interstitial radiation is often indicated in the treatment of hemangiomas, especially in angiomatous masses[2], and in infants requiring a controlled dosage and accurate placement of minimal doses to protect cartilage and the eye.[6,8,9] While the usual dosage is 0.5 millicuries to 1.5 millicuries, placed in gold seeds below the tumor and 2 centimeters apart, Brown has repeatedly advocated the use of the much smaller dose, 0.1 millicuries.[6,8,9,10]

Surgical Excision

Surgical excision lends itself very often to cure of the lesion, either alone or as a part of a staged procedure for control of the tumor. Because of the wide resection, usually employed, and "unsightly scars," Watson and McCarthy stated that excision should be limited to those small papillary tumors, to bulky capillary tumors in areas where scars can be concealed by clothing, and for resistant angiolipomas and angiofibromas. Brown stated that surgical excision and closure by suture is the method used when there is sufficient tissue to prevent distortion of a feature.

A graft or flap may be required for closure. Elkins and Cooper[4] emphasize that total eradication of the tumor is the only cure. With protection to and consideration of features and function they advocate surgical excision of the entire lesion. They point out that from the surface, extension of the lesion is deceptive and feasibility of complete surgical resection can be determined only by surgical exploration. They report 19 cases of extensive hemangiomas treated successfully by surgical exploration.

Larger and more extensive hemangiomas involving entire extremities present problems already mentioned. It is difficult to arrive at a decision to sacrifice an arm or leg by amputation without first attempting multiple staged procedures to control propagation of endothelia lined spaces. In addition to use of the therapeutic steps mentioned, multiple chromic cat gut sutures, which are placed through and through skin and cavernous spaces and tied, tend to promote thrombosis, probably based on both blood stasis and the irritative effect of the cat gut on the tissues.

Partial excision of large portions of the masses will at times promote closure of the extra vascular spaces. Thus, a functioning limb should never be amputated as long as any less radical procedure promises support and as long as the nerve and blood supply to the limb is intact.[10]

Summary

1. The probable congenital origin of hemangiomas as organoid tumors serving no useful function has been discussed.

2. A classification of hemangiomas based on comparative clinical pathological and therapeutic considerations is repeated.

3. Principles of treatment based on controlling the tumors without injury to or disturbance of growth of surrounding parts have been considered with special reference to thermal cauterization, injection of sclerosing agents, irradiation and surgical excision.

Bibliography

1. Schafer, Paul W., Pathology in General Surgery, P. 27, The University of Chicago Press, 1950.

2. Watson, William J. and William D. McCarthey, Blood and Lymph Vessel Tumors, A Report of 1,056 Cases. S G O 71: 569-588, 1940 (Nov.).

3. Karsner, H. T., Human Pathology, P 303, J. B. Lippincott Company, 6th Ed., 1942.

4. Elkins, D. C. and F. W. Cooper, Jr., Extensive Hemangiomas, Report of Cases; S G O 84: 897-902, 1947.

5. Wright, I. S., Vascular Disease in Clinical Practice, The Year Book Publishers, 1948, P. 474.

6. Brown, J. B. and M. P. Fryer, Treatment and Repair of Defects. A Report of Minimal Radiation Dosage and of Multiple Suture Procedure. S G O 95: 33-44, 1952.

7. Leavell, Ullin, Personal Communication.

8. Brown, J. B., F. M. McDowell, and M. P. Freyer; Radiation Burns Including Vocational and Atomic Exposures. Ann. Surg. 130: 593-607, 1949.

9. Brown, J. B. and M. P. Freyer, Treatment of Hemangiomas; A M A Arch. of Surg. 65: 417-421, 1952.

10. Brown, J. B. and M. P. Freyer and Frank McDonald; Hemangiomas; Ann. Surg. 137: 652-659, 1953.

EVALUATION OF RESERPINE AND METHYL PHENIDYLACETATE USED SEPARATELY AND IN COMBINATION IN CHRONIC PSYCHOTIC PATIENTS*

Harold McPheeters, M.D., W. Walter Fox, M.D.**

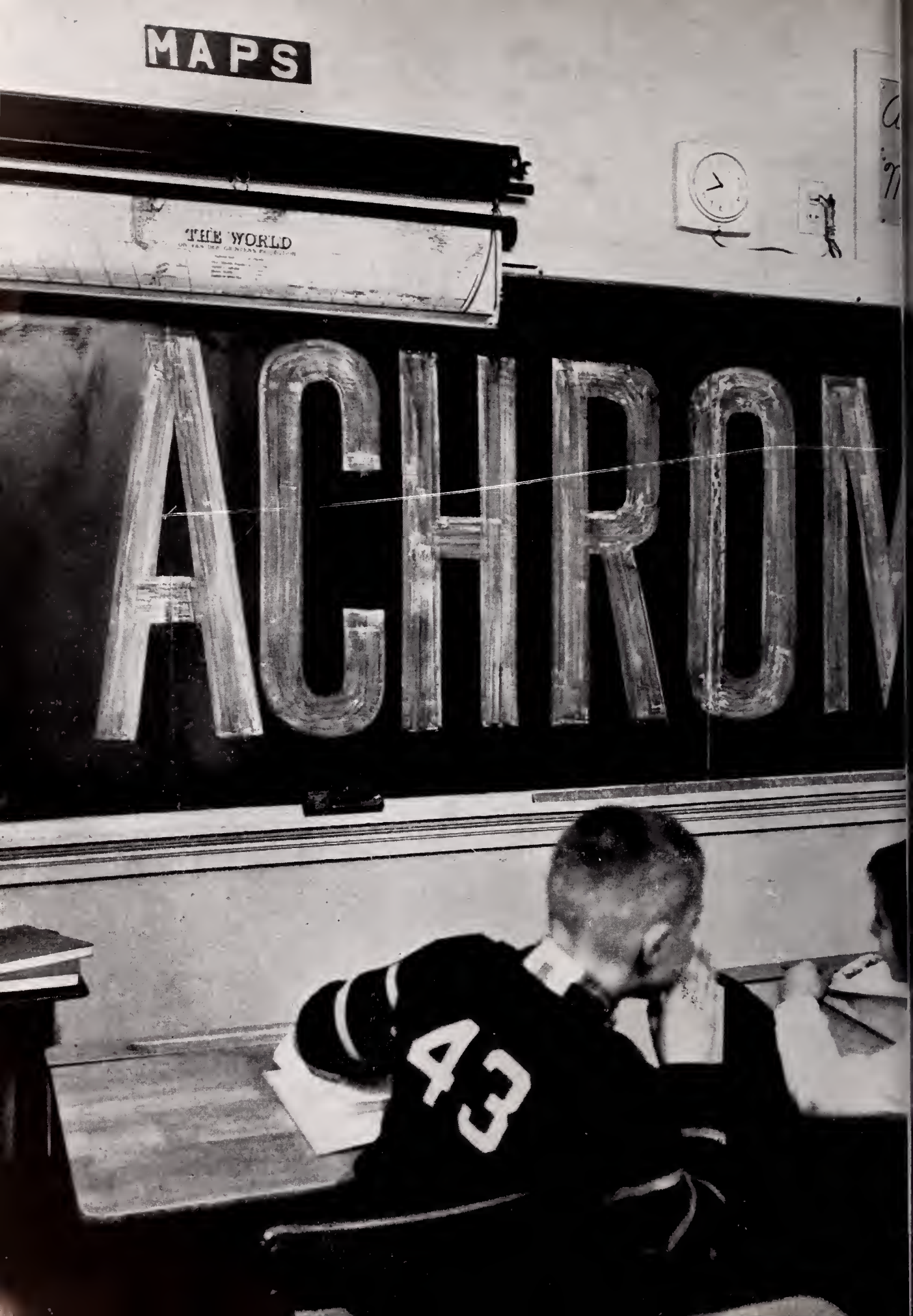
Louisville

RESERPINE (SERPASIL) is known to have marked tranquilizing effects in disturbed, agitated persons. Earlier studies have reported favorable tranquilizing action from this drug in from 40 to 90 per cent of patients. Many of these studies have been done without controls, and for this reason a double blind technique was felt desirable in this study. Many of the earlier experiences with reserpine in psychotic persons have shown a tendency for the patient to become apathetic and lethargic on even small doses of the drug. A new analeptic drug, methyl phenidylacetate (Ritalin [Ciba]), has been reported to be effective in helping patients attain a degree of alertness and drive. It has been used in mild depressions and also to overcome the apathy sometimes seen with reserpine. It was decided to try to design a study which would show the effect of this drug as an analeptic in chronic psychotic patients, both by itself and in combination with reserpine. A double blind technique was chosen for this part of the study also.

It has further been noted that nearly all earlier studies of reserpine and Ritalin have measured only changes in clinical behavior. There has been little attempt to quantify any changes in intellectual capacity, memory, or physical strength or endurance in earlier studies. It is not known whether either of these drugs has any effect on either intellectual performance or physical performance, but since these are both somewhat objective, measurable areas of human behavior, it was felt wise to try to include some attempt to measure changes in these areas.

*Technical assistance was given frequently by the Department of Psychology of Central State Hospital and is gratefully acknowledged.

**Assisted by John Wilson, Robert Blake, and Elvis Thompson, students at U. of L. School of Medicine.


MAPS
THE WORLD
ACHROM
43



ACHROMYCIN*

Tetracycline *Lederle*

in the treatment of

respiratory infections

January and his associates[1] have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

No matter what your field or specialty, ACHROMYCIN can be of service to you. For your convenience and the patient's comfort, Lederle offers a *full* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.



For more rapid and complete absorption.
Offered only by Lederle!

[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*REG. U. S. PAT. OFF.

PHOTO DATA: 8 X 10 VIEW CAMERA—WIDE ANGLE LENS, F.32, 1/10 SEC., FLOODS AND SPOTS, ROYAL PAN FILM.

Method

Ninety-eight patients, equally divided by sex, were selected from the chronically disturbed wards of Central State Hospital at Lakeland, Kentucky. They were not chosen from any particular diagnostic groups or from any particular age groups. They were patients whose behavior patterns were quite well known because they had been in the hospital over a period of months or years. Patients' stay in the hospital ranged from one to 25 years. The average length of hospitalization was seven years and eight months. The main criteria for inclusion in the study were that the patient should be able to cooperate on the testing and he should have shown either regular or periodic behavior which might be expected to respond to a tranquilizer drug. The types of behavior that we felt might be expected to respond to a tranquilizer drug included motor restlessness, agitation and tenseness, as well as noisiness, destructive or assaultive behavior, and hostile verbal outbursts. Patients' ages ranged from 22 to 74 with an average of 45.5 years.

Diagnostic groups included:	No. of Patients
Schizophrenic reaction	
Chronic undifferentiated type	23
Paranoid type	42
Catatonic type	5
Hebephrenic type	9
Simple type	3
Chronic Brain Syndrome (unclassified)	2
Mental deficiency with psychosis	5
Sociopathic personality	1
Chronic Brain Syndrome with convulsive disorder	2
Chronic Brain Syndrome with CNS lues	2
Manic-depressive reaction, manic type	3
Paranoid condition	1

Twenty-three men were Negroes. All other patients were white.

Most patients had been given previous treatments, especially courses of electroshock, earlier in their hospitalizations. Improvement with other methods of treatment was usually very transient. A few patients had received earlier courses of treatment with Chlorpromazine, and a small number (4) were transferred to this study directly from Chlorpromazine therapy.

Each patient was given the following studies before the project began and again at the end of two months of drug administration:

1) Weight was recorded on each patient.
2) Finger ergograph records were made if the patient would cooperate. (Only a few refused to cooperate.)
   The finger ergograph is a device in which the subject lifts and lowers a two pound weight a standard distance over a pulley with the hand in a fixed position. Recordings were made of the number of repetitions the patient was able to perform and the time required. Each patient was earlier instructed to continue lifting and lowering the weight as long as he was able to do so. Improvement was recorded when a patient was able to increase the number of repetitions and the time, or if he was able to perform more repetitions in a shorter time.
3) A psychological test to score visual retention and mental control. The test chosen was Part VI of the Wechsler Memory Scale. This test consists of a series of three cards on which are simple geometrical patterns. The patient is asked to reproduce the design on a separate piece of paper after a period of observation. The reproductions were then scored according to standard procedures.
4) A behavior check card was kept by the regular ward attendant to be checked twice a week on each patient. This listed 20 items of behavior that psychiatric aides had had previous training in identifying.
5) A clinical interview was conducted by an examiner who was a psychiatrist. This evaluation was also determined by a brief interview with the regular ward attendant who had known the patient over a period of several weeks. This was an evaluation of mental status with particular attention to tension, agitation and degrees of interest in ward affairs.
   All of these procedures were conducted before medication was started, and after two months of drug administration.

By a random selection process (toss of a coin), each patient was assigned to a combina-

tion of medicine that was known to those who worked with the project only by a letter. The tablets*, Serpasil, Serpasil placebo, Ritalin, and Ritalin placebo, were each assigned a letter and medicines were all known only by this letter to all workers, until after the results were compiled. Workers did know that two drugs and placebos were being used, but they had no way of knowing which letter was assigned to which drug.

The dosages used throughout were: Serpasil or Serpasil placebo one mgm bid, and Ritalin or Ritalin placebo 10 mgm tid. This dosage schedule was kept throughout the study although several other studies have reported that these dosages might be given just once daily with the same result as might be expected from multiple doses throughout the day. No attempt was made to change dosages upward or down, and in no case was it necessary to change the dosage because of toxic effects, etc. The study ran for two full months.

Results

1) Weight

Not all of the weight records were considered reliable, and two wards' records were discarded because they were incomplete. The patients on both placebos showed no appreciable weight changes in either direction.

In the patients receiving Serpasil and placebo, 10 patients gained an average of five pounds each, while only two patients lost small amounts of weight.

In the patients receiving Ritalin, 11 patients showed an average weight loss of 1.7 pounds, while only four patients showed slight gains.

In the patients receiving both Ritalin and Serpasil, eight patients gained an average of five pounds each, while five patients lost an average of three pounds each.

2) Ergograph

There were a few patients who refused to cooperate on the ergograph studies, while some others were too withdrawn or preoccupied to work effectively. However, it was decided to continue this part of the study regardless of such behavior, for behavior such as withdrawal and preoccupation might be expected to respond to these drugs. The results:

Chart 1—Ergograph

	Refused to Cooperate	Improved	No Change	Worse
Double Placebo	3	12	6	6
Placebo & Ritalin	2	10	6	7
Placebo & Serpasil	1	11	2	10
Ritalin & Serpasil	1	16	1	4
Totals	7	49	15	27

3) Psychological testing

The initial peformance on the psychological test ran from very good to no performance at all. It was noted that many patients who were suffering from functional psychoses alone, were found to show a fairly typical performance of the type usually found in organically brain damaged patients. Also, an intermediate testing was made using a standard alternate of the same test. Results on these patients often showed almost no correlation between the two different standardized forms of the same test. The results:

Chart 2—Psychological Testing

	Improved	No Change	Worse
Double Placebo	6	9	5
Placebo and Ritalin	6	13	5
Placebo and Serpasil	2	17	2
Serpasil and Ritalin	7	12	3

4) Ward evaluation

The ward attendant's behavior check form and the technique used were found to give almost totally unmeasurable results. In a subsequent test, the reliability of the form itself was found to be poor. Also, it was found to be too technical in its wording for use by ward attendants although it had been simplified several times before it was used. There was found to be a major flaw in the technique of having each previous rating in sight at the time of each subsequent rating. Thus, the attendants tended to rate each time the same as at the previous rating. All in all, it is impossible to make any kind of effective evaluation of this part of the study.

5) Clinical evaluation

The psychiatrist's clinical evaluation was based on a personal interview with the patient, but also included the results of a brief interview with the ward attendant regarding an evaluation of the patient's usual ward behavior. The

Note. The Serpasil and Ritalin and placebos for this study were supplied through the courtesy of Frank A. Travers, M.D., Ciba Pharmaceutical Products, Summit, N. J.

criteria for improvement in this clinical evaluation were not exactly defined. However, they included changes in mental content, psychomotor activity, affect and general reality testing. The ward attendant was questioned to determine whether such changes were strictly temporary or whether they were fairly consistent patterns observed day by day. The results:

Chart 3—Clinical Impression

	Improved	No Change	Not Recorded
Double Placebo	4	22	1
Placebo and Ritalin	13	11	2
Placebo and Serpasil	11	11	3
Serpasil and Ritalin	9	13	0

The column marked "Not Recorded" included patients who either went home (one) or in whom it was certain that the medication was not actually taken regularly.

There were no complications of any kind in any patients on the dosages used. Laboratory studies were not conducted.

Conclusions

1) Weight

There seemed to be a fairly consistent tendency for patients taking Serpasil alone to gain small amounts of weight, while there was a similar consistent trend for patients taking Ritalin alone to lose small amounts of weight. Whatever physiological mechanisms are responsible for these trends seemed to neutralize each other when the drugs were combined, for then there was no significant weight change.

2) Ergograph

The ergograph proved to be a difficult test to evalute in these chronically psychotic patients. However, applying the Chi Square Test to ascertain whether the figures obtained show any significant differences, we find that both Ritalin alone and Serpasil alone show no significant differences from the double placebo group. However, the probability of grouping seen in the case of Ritalin and Serpasil in combination being chance in comparison to the double placebo is less than one in a hundred. This would indicate a significant level of improvement.

The test procedure was an extremely trying one for the staff, involving long explanations and close attention. It should be investigated further in evaluating drugs of this type which influence fatigue, attention and motor performance, but it is not recommended for relatively large scale studies of this sort.

3) Psychological testing

Statistical evaluation of the results of the psychologcial testing shows that there are no significant differences between any of the groups on this test.

In future studies of this type, it is recommended that a preliminary study be made to find a test that gives better reliability and a more sensitive index of change than this choice. However, it is felt that further efforts in the direction of measuring performance on psychological tests should be made in the evaluation of these chemotherapeutic agents.

4) Ward evaluations

Because of many technical obstacles, it was impossible to make any kind of effective evaluation from the ward attendants' behavior check cards. However, this part of the study had considerable value in that it kept the attendants on their toes for changes in the behavior of patients. Thus even though the cards could not be statistically rated, the ward attendants' observations were better able to help the psychiatrist in his evaluation. For a satisfactory statistical evaluation of such a behavior check card, the study should have: 1) A standardized behavior check card, 2) a special team of research attendants whose reliability is known and 3) extremely close supervision.

5) Clinical impression

Using the Chi Square Test again, we find that all of these results show a significant variation in the groups receiving medications in contrast to the group receiving placebos alone. The best results were obtained in the group receiving only Ritalin. This may be the result of the psychiatrist's looking for increased responsiveness and alertness on the part of the patient as a criterion for improvement. It is unfortunate that this study was designed with relatively low and fixed dosages of both drugs throughout the study. This did not give the drugs opportunity to be as fully effective as they can be with flexible dosages. However, at the start of this project, it was felt that varying the dosages would soon reveal the blind code and thereby spoil the control aspects of the study. Now a technique has been devised whereby flexible dosages can be given without revealing the blind and a further study along these lines is

being planned. However, to find a significant change in such long-term, psychotic patients with small, fixed dosages indicates that the drug effects are considerable and deserve further clinical investigation of this type.

Summary

A two-month-long study of reserpine and methyl phenidylacetate was undertaken on 98 chronically disturbed psychotic patients from the wards of Central State Hospital. The patients were given dosages of one mgm reserpine or placebo bid and 10 mgm methyl phenidylacetate or placebo tid throughout the study. This was a double blind study in which some patients received only placebos, others only reserpine and placebo, others Ritalin and placebo, and others reserpine and Ritalin according to a random selection known to no one during the study.

Areas of measurement included weight, physical performance on a finger ergograph, psychological testing for visual memory retention and a clinical interview. Patients did significantly better on the ergograph studies when taking reserpine and Ritalin together. The results on the psychological tests were not significant. On clinical evaluation, the patients all did significantly better on any active drug combination than on the placebos alone. However, greatest improvement was found on Ritalin alone. It is felt that small fixed dosage schedules have hampered the chance for these drugs to do their best job, and another project is being planned to use flexible doses on a double blind technique with these two drugs.

Bibliography

1. Meier, R., Gross, F. and Tripod, J.: Klin. Wchnschr. 32: 445 (May 15) 1954.
2. Drassdo, A. and Schmidt, M.: Med. Monatsschr. 8: 390, 1954*.
3. Ferguson, J. T.: Improving Senile Behavior with Reserpine and Ritalin: J.A.M.A. Vol. 160, No. 4 (Jan. 28) 1956, Page 263.
*Ritalin Brochure, CIBA Pharmaceutical Products, Inc., Summit, New Jersey.

CASE DISCUSSIONS

FROM THE UNIVERSITY OF LOUISVILLE HOSPITAL
CARCINOMA OF ESOPHAGUS

Patient Protocol

L. R.*, a 61-year-old white female, was admitted on February 10, 1956, complaining of difficulty in swallowing for the past two to two and one-half months duration. About the first of November 1955, the patient noticed some vague pain in the right upper quadrant of her abdomen which radiated to the back. She consulted her family physician at that time and was diagnosed to have gall-bladder disease and was placed on a low fat diet. Following that she had frequent episodes of "indigestion" but she did not have any difficulty in swallowing until the first of January, 1956, when she noticed that solid foods seemed to lodge in her chest before going down into her stomach. She was not particularly concerned and restricted herself to a soft diet. The obstructive symptoms gradually progressed, and, on February 10, 1956 she became choked while swallowing a piece of chicken. While attempting to bring up the food, she spit up some bright red blood. She also lost about 20 pounds in weight in a two month period.

Physical Examination

The patient was a well-developed and fairly well-nourished white woman in no acute distress. The blood pressure was 126/78, pulse 76, temperature 96.7. General physical examination was entirely within normal limits.

Laboratory Findings

The hemoglobin was 11.5 grams. Urinalysis was negative. The white blood count was 6,300 with normal differential. A barium swallow study (Fig. 1) revealed a long irregular constructing lesion in the esophagus starting approximately at the level of the aortic arch measuring about six centimeters in length. There was a moderate degree of obstruction and delayed descent of the barium. At esophagoscopy, the lesion was seen at about the level of the aortic arch. The esophageal lumen was markedly narrowed and introduction of the esophagoscope beyond the constriction was not possible. A biopsy was taken and was reported squamous cell carcinoma.



Fig. 1 Oblique views of barium filled esophagram showing long irregular narrowing with shelf-like defect characteristic of an intraluminal tumor.

Treatment

On March 25th, a thoracotomy was performed. The lesion was found to be nonresectable due to extension beyond the esophagus. The patient was referred to the Department of Radiology for radiation therapy. The entire lesion with adequate margins at either end was irradiated by a gamma ray beam with the cobalt-60 unit. Two straight opposing

*Louisville General Hospital No. 283585.

ports were used. The calculated tissue dose to the lesion was 5,050 roentgens in 33-treatment days. During treatment, the patient was maintained adequately on a liquid diet and at no time was tube feeding deemed necessary. She was also given frequent small blood transfusions and moderate doses of thorazine. She lost a total of three pounds of weight during the five-weeks treatment period. A repeat



Fig. 2 AP and lateral views following treatment showing complete regression of tumor and smooth funnel-shaped narrowing of the involved segment.

esophagram (Fig. 2), about six weeks following treatment, showed the site of previous disease now was smooth in outline and presented a uniform funnel-like narrowing. The esophageal wall retained moderate distensibility with each swallowing of the barium bolus. She soon returned to a soft diet and had regained the 20 pound weight loss within a short period.

Discussion

Herbert T. Ransdell, M.D., Department of Surgery: At present the trend seems to be toward pessimism in surgical treatment of carcinoma of the esophagus particularly in those lesions of the upper one third. The duration of growth before symptoms occur, the extension of the growth into immediately adjacent vital structures, the advanced age of the average patient, the poor general condition and high malignancy of the growth and tendency for early metastases all add up to poor prospect for cure.

Phemister reports a 22.5 per cent five-year survival of resected cases, but found only 40 of 89 cases explored resectable. There was a 12.5 per cent overall mortality rate, but a 33 per cent mortality rate with the higher resections. Sweet reports a five-year survival of 17 per cent for low resections and four per cent for high resections in 254 resected cases with a 11.6 per cent mortality for low resections and 24.3 per cent for those of the mid esophagus, but does not include lesions of the cervical esophagus as he does not consider them generally amenable to surgery. Many of his cases are also resections done only for palliation. Resection and anastomosis at present provides the best method of palliation of carcinoma of the esophagus and cardia.

We believe that unless there is evidence of involvement of the tracheobronchial tree, massive distant metastases, extensive mediastinal extension into vital structures, or poor physical condition, the patient should have the benefit of exploration and resection with en bloc removal of regional lymph nodes if possible, and resection of the local lesion and restoration of gastrointestinal continuity as a palliative procedure if all the cancer cannot be removed provided such procedure does not present insurmountable complications or a prohibitive mortality. Palliative resection of lesions of the upper one third is not felt warranted, however, because of a mortality of some 60 per cent.

All patients with non-resectable lesions, particularly those of the upper one third, should be referred to the radiologist for evaluation, as many can be benefited with radiotherapy.

J. T. Ling, M.D., Department of Radiology: For the overwhelming number of patients with esophageal carcinoma, the problem remains that of palliation. At the meeting of the American Association of Thoracic Surgery in May, 1952, Ravitch et al stated in summary that "results of extirpation of carcinoma of the esophagus to date have been so discouraging as to raise serious question concerning the value of direct attack." Perhaps we should in this particular type of cancer reorient our outlook and to a degree relax in our emphasis on "cure" at any price. This does not mean that every reasonable attempt at permanent control shall not be made. But cancer of the esophagus is mainly a disease of the older age group with the average age of around 60 and with the ma-

jority of patients in the sixth and seventh decade of life.

The main reason for the high incidence of failures is the tendency of esophageal carcinoma to spread early throughout the rich lymphatic network of the esophageal wall with deposit in the intramural lymph nodes along the esophagus and in the parasophageal and mediastinal lymph nodes. Since the intramural spread may extend along the entire length of the esophagus, any procedure, surgical or radiological, that includes only a part of the organ, is apt to leave active disease.

There can be no doubt that, with adequate radiation treatment, the primary focus in the esophagus can be controlled with considerable consistency. It is likely that the involvement of regional lymph nodes with very few exceptions demarcates the borderline between curability and incurability by either surgery or radiation therapy. Our experience has shown that we are unable to contol lymph node involvement secondary to epidermoid carcinoma by external irradiation. It is possible that in the presence of minor lymph node involvement, surgery in a certain number of incidences may succeed in eradicating the entire disease. The sharp drop of curability in the presence of lymph node invasion is well recognized in other cancers such as those of the breast and tongue. It appears justified that the patients in whom the likelihood of surgical resection with permanent control is nil or unreasonably small may still receive equal palliation by adequate radiation therapy with considerably less mobidity inherent in the procedure. Restoration and maintenance of oral feedings could be accomplished in over 50 per cent of the patients treated with radiation. Complete or nearly complete primary freedom from symptoms (almost normal deglutition and radiological improvement of the passage) could be obtained in a very high percentage of the adequately treated patients. In many instances the patients were able to swallow up to the time of death which in most cases was due to metastases and cachexia. The specific purpose of palliation in this type of cancer is of course the prevention of the misery of starvation. Gastrostomy has in general been abandoned as unsatisfactory. It prolongs life without comfort and happiness. Palliative results as measured by symptom-free survival (with restoration of esophageal function) after one, two and three years are the same following surgical resection with anastomosis or adequate roentgen therapy.

There is a trend in the treatment of patients with squamous-cell carcinoma of the esophagus to reserve for radiation therapy those located in the upper half of the thoracic esophagus. The best palliation, with the same percentage of cures or long-lasting arrests, has been secured by techniques aiming only at producing regression of that part of the tumor which blocks the lumen of the esophagus, no attempt being made to include all probable disease. If supervoltage is to be used to its best advantage one should choose the technique of two opposing ports, which can be used easily at one or two mev. or higher voltage levels, and not at 250 KV. If one wants to be curative, one must include long segments of esophagus above and below, and large areas of mediastinum as the lymph nodes of that area are almost always involved. Radical radiation therapy is warranted only if one has attempted to rule out the existence of distant spread. In particular, the presence of subdiaphragmatic retroperitoneal lymph nodes should be ruled out as we know they are frequently involved.

EDITORIALS

THE METHODIST-EVANGELICAL HOSPITAL

ANNOUNCEMENT of reactivation of plans for construction of the Methodist-Evangelical Hospital in Louisville must be received gratefully by all. Physicians who daily have difficulty finding accommodations for their patients have felt great disappointment that the construction of a new hospital should be so long delayed and persons requiring hospitalization in this area must often stand in line and wait while necessary or even urgent treatment is delayed. Rapid growth in population and increased demand for hospital care have tended to keep the shortage of beds at/or near the critical point for the past 10 years. It would appear that increased hospital facilities throughout the State would relieve this situation in the urban areas but it does not seem to have done so to any satisfactory extent.

Those most interested in the development of a great modern medical center in Louisville rejoice at the decision to make this new hospital a part of that center. While there are sound and laudable reasons for placing it in the outlying area, there appear to be more compelling reasons for building in the medical center. It will substantially strengthen the position of medical teaching and will improve the service to patients by bringing them into close contact with the enlarged and improved laboratory and research facilities of the medical school.

The church organizations behind this project no doubt hope that their new institution will grow in size and usefulness to their constituency. It would seem that over a period of years this growth will be more substantial in a central rather than a peripheral location. The development of a sound and attractive intern and resident program is an important requisite for such growth. This can almost certainly be better accomplished as an integral part of the medical center and with a continuing affiliation with the School of Medicine.

The proposed size of the new hospital is its most disappointing feature. It would seem shortsighted for any organization, especially those as large as the churches concerned, to build a new hospital of less than 300 beds. The proper operation of a small hospital is economically difficult. Facilities such as nurses training school, physical therapy and rehabilitation departments are difficult for a small hospital to support. The 220 beds proposed will certainly be welcomed with gratitude but even that number of additional beds will be promptly absorbed by the present demands, and our bed shortage, though less acute, will continue to exist. We must build with greater vision if we are to meet the challenge of an already over-crowded and rapidly growing community. There is no new hospital, other than this one, even in remote prospect of consideration now. Sts. Mary and Elizabeth Hospital will be rebuilt with a greater capacity. That too will help a great deal but will not alleviate our shortage.

Sam A. Overstreet, M.D.

WE ARE DOING BETTER

THIS COMPLETES my fifth and last year of membership on the Professional Relations, or Grievance Committee, of the Kentucky State Medical Association. It may be appropriate to record some observations relating to this experience. First of all, I must pay tribute to the varying members of the Committee, all past presidents of the Association, all men whose time is valuable, and most of them living a considerable distance from State Medical Association Headquarters, where all meetings have been held. These men have come regularly to the called meetings of the Committee without complaint, and have spent tedious sessions carefully sifting the merits of a considerable number of complaints and devis-

ing a solution equitable to all. Their work has been rewarded in the accomplishment of a friendly understanding and adjustment for most of the points at issue.

From the first year of its operation until now there has been a pleasing decrease in the number of cases presented. Rather wide publicity was given at first to the formation of such a committee and, as would be expected, the public responded with varied complaints sent directly to the Central Office. The very knowledge that they had an official recourse for their grievances and that they were treated with honesty and fairness has seemed to instill a certain degree of security and confidence resulting in a decrease in the number of complaints filed. Most county societies also have set up local committees for the same purpose. The policy has prevailed that wherever possible the matter has been settled locally. This has materially decreased the work of the State Committee which has served as a last appeal for difficult cases, fewer and fewer of which have reached us.

Complaints have been generally of three characters—(1) charges of neglect or improper procedure on the part of the physician; (2) fees which were thought to be excessive and; (3) criticisms by neurotic or unreasonable persons who generally tend to be dissatisfied by any explanations or reasons given regardless of how carefully stated, how often reiterated, or how well substantiated by any evidences offered. No one of these types has seemed to predominate. Without exception those of the first two categories have eventually been adjusted to the reasonable satisfaction of all concerned. There remain in our files, however, a few of the third category upon which no final agreement has been reached.

Viewed from this very good vantage point, it appears that the members of the Kentucky State Medical Association maintain good public relations. It is really surprising that with so much medical and surgical care dispensed by so many physicians and surgeons to so many people of varied temperaments and personalities, there is not more frequent conflict and dissatisfaction than has been experienced. It seems that many people feel the medical profession generally is inconsiderate of the public welfare, but their "own personal" physician or surgeon is the exception. That is all to the good. If we can, individually, keep the confidence and high esteem of our own clientele, the attitude of the public in general will continue to improve. Patients generally are appreciative, tolerant and understanding. They would rather think well than ill of physicians. A little patience, sympathy and effort to appreciate their viewpoint will always pay us dividends in good will and public esteem.

Sam A. Overstreet, M.D.

ORGANIZATION SECTION

Plans for '56 Annual Meeting are Nearing Completion

Plans for the 28 different scientific sessions of the 1956 KSMA Annual Meeting, September 18-19-20 in Louisville at the Columbia Auditorium are nearing completion, according to Gant Gaither, M.D., Hopkinsville, KSMA President.

The preparations for the two new features of the meeting, scientific movies and post-graduate refresher courses, are complete. The two will run simultaneously from 8:00 to 10:00 o'clock each morning. The refresher courses will include sessions on trauma, medicine and pediatrics. The movies have been carefully selected from the library of Davis and Geck, and will include coverage of a wide range of medical subjects of primary interest to the general practitioner.

Eleven specialty groups will hold scientific meetings during the Wednesday afternoon session. A twelfth group, the Kentucky Association of Public Health Physicians, will hold a business session at 1:45 PM Wednesday. The program will be announced later.

The annual President's Luncheon will again be held in the Roof Garden of the Brown Hotel. William McGrath, Cincinnati, employer's delegate to the International Labor Organization, Geneva, will be the luncheon speaker. Many will remember him from the dynamic address he presented at the County Society Officers Conference in March.

Twelve scientific exhibits are scheduled for the '56 session. These will all be presented by Kentucky physicians.

Sixty-four technical exhibitors will present their latest developments in medicine, instruments, etc., in the giant exhibit hall at Columbia Auditorium.

A program flyer with full details of the refresher courses, general assembly meetings and specialty group meetings has been mailed to every Kentucky physician.

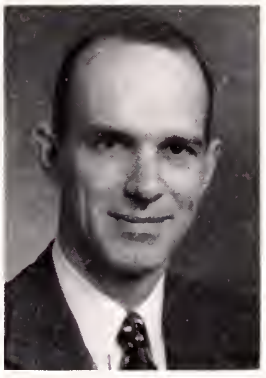
New KSMA Members

These physicians were recently added to the KSMA membership roster:

James R. Barnes, M.D., Louisville
B. W. Barron, M.D., Louisville
Robert R. Burnam, M.D., Louisville
Alvin M. Churney, M.D., Louisville
John L. Creech, Jr., M.D., Louisville
Donne O. Demunbrum, M.D., Louisville
Earl K. Frasher, M.D., Louisville
Mervel V. Hanes, M.D., Louisville
Rand C. Johnson, M.D., Louisville
Robert R. Kidd, M.D., Louisville
Leslie W. Langley, M.D., Somerset
John W. Miller, M.D., Louisville
Jack L. Mulligan, M.D., Louisville
Glenn R. Powell, M.D., Fairdale
Broadus A. Richardson, M.D., Harlan
E. W. Sandlin, M.D., Newport
William K. Skaggs, M.D., Taylorsville

Syracuse Dean Named Head of UK Medical School

William R. Willard, M.D., Syracuse, New York, has been named dean of the University of Kentucky Medical School and vice president of the proposed medical center. The appointment was made official at a meeting of the UK executive committee, July 20.



Dr. Willard

The 47-year-old dean of Syracuse College of Medicine of the State University of New York for the past five years, was, according to published reports, among four persons mentioned prominently for the position last spring. He is acting as professional consultant on the medical school construction plan.

Dr. Willard was born in Seattle, Washington. He received his MD degree from Yale in 1934; interned at Johns Hopkins Hospital in 1934-35, and was assistant resident at Strong Memorial Hospital in Rochester, New York in 1935-36. He received the degree of Doctor of Public Health from Yale in 1937.

From 1944 to 1946, following six years as Deputy State Health Officer for Maryland, Dr. Willard as a surgeon with the United States Public Health Service, was in charge of malaria control in war areas. He later served as acting director of the Public Health and Welfare Department of the United States Military Government in Korea.

In 1946 Dr. Willard was appointed assistant professor of public health at the Yale School of Medicine. In 1948 he became associate professor and in 1951, professor. He served as assistant dean in charge of post-graduate medical education at Yale from 1948-1951.

A fellow of the American Public Health Association, Dr. Willard has been active in the Central New York Regional Hospital Council and the Handicapped Children's Association.

Of his new position Dr. Willard said, ". . . it offers an opportunity which is given to relatively few people, namely to develop a medical center from the very beginning."

Dr. Willard is married and has three children; Karen, 18, Marian Claire, 15 and Judy 12.

Scientific Movie Program Announced by Dr. Noer

The program schedule for the scientific movies for the 1956 Annual Meeting September 18-20, was recently announced by Rudolf J. Noer, M.D., chairman of the Subcommittee on Scientific Assembly.

The movies which will run simultaneously with the refresher courses each morning from 8:00 to 10:00 o'clock have been carefully selected from the library of Davis and Geck. "They have been chosen to cover as wide a medical range as possible to be of interest and service to the average general practitioner," Dr. Noer said.

The schedule for the movies which will be shown in the main auditorium of Columbia Auditorium follows:

Tuesday, September 18, 8:00 AM

C-197 Hemorrhage from Duodenal Ulcer
Hilger P. Jenkins, M.D., and Associates

CS-141 Surgery for Massive Hemorrhage from Gastroduodenal Ulcer
John D. Stewart, M.D.

CS-636 Surgical Treatment of Diverticulitis of the Sigmoid
R. K. Gilchrist, M.D.

C-797 Polyps of the Large Intestines
Hilger P. Jenkins, M.D., and Associates

Wednesday, September 19, 8:00 AM

CS-650 Early Management of the Severely Burned Patient
Edwin H. Ellison, M.D.

CS-707 Treatment of Simple Head Injuries
Loyal Davis, M.D.

C-180 Purposeful Splinting
Sumner L. Koch, M.D., and Associates

CS-484 Tendon Injuries
Michael L. Mason, M.D.

Thursday, September 20, 8:00 AM

C-127 Cancer of the Female Breast
Frank E. Adair, M.D.

C-183 Surgical Treatment of Varicose Veins
Henry N. Harkins, M.D.

CS-473 Surgical Technique of the Several Types of Skin Graft
Herbert Conway, M.D.

C-182 Amputations for Occlusive Arterial Disease
Gerald H. Pratt, M.D.

Eight New Members Elected to Board of Consultants

Eight new members of the Board of Consultants on Scientific Articles were elected at the July 11 meeting of the Advisory Committee, to the Editor, to replace the eight who retired June 30.

The new consultants are: German P. Dillon, Jr., M.D., Lexington; Maurice Walsh, M.D., Covington; Stanley Parks, M.D., Lexington; Pat Imes, M.D., Louisville; James Ward, M.D., Paducah; William Roland, M.D., Ashland; Thomas Crume, Jr., M.D., Owensboro; and Robert E. Buten, M.D., Ft. Thomas.

Retiring members are: Everett H. Baker, M.D., Louisville; John Dixon, M.D., Owensboro; George Greene, M.D., Lexington; R. Arnold Griswold, M.D., Louisville; O. Leon Higdon, M.D., Paducah; James Keeton, M.D., Ashland; Frank Moore, M.D., Bowling Green and Alvin Poweleit, M.D., Covington.

The work of the retiring members who have served for three years was praised by Guy Aud, M.D., Louisville, chairman of the Advisory Committee and Woodford B. Troutman, M.D., Louisville, Journal editor. In a joint statement they said "we thank each of these men who has worked to better the quality of the Journal's scientific material and who has done so without praise or recognition."

The Board is made up of 24 members. Eight of these retire each year after three years of service—they are unable to succeed themselves.

Louisville Pathologist Given $3,800 Outboard Cruiser

Friends of A. J. Miller, M.D., presented him with a $3,800 outboard cruiser at the River Valley Club, Louisville, on July 26. The gift, which moved the former Iowa farm lad to tears, was in recognition of his 28 years of outstanding service as chairman of the department of pathology, University of Louisville Medical School and General Hospital, from which post he resigned July 1.

Dr. Miller, also chief pathologist at Jewish Hospital, will continue to serve as professor of pathology at the Medical School as William M. Christopherson, M.D., takes over the chairmanship. Recognized by his colleagues as a wise and kindly student counselor, Dr. Miller has four times received the student plaque given by each senior class at the Medical School to the teacher they consider outstanding.

In addition to the 22 foot craft, with a 40-horsepower outboard motor, Dr. Miller and his wife received a leatherbound book of letters and telegrams of tribute and two silver bowls with the inscription:

"Aura James Miller, M.D. To you who have given so much to all of us by concept, by precept, of science, of art, of humanity—and all with humility. We are most grateful. Your friends, July, 1956."

12 Scientific Exhibits Scheduled for Meeting in September

Twelve scientific exhibits, all prepared by KSMA members, will be displayed at the 1956 Annual Meeting, September 18-20, according to Everett L. Pirkey, M.D., Louisville, chairman of the Committee on Scientific Exhibits.

"The interest shown in these exhibits by both members and exhibitors is gratifying and most appreciated," Dr. Pirkey said.

This year's exhibits will cover a wide range of subjects of interest to the Kentucky physician.

The exhibits and exhibitors are:

"Letterer Siewe's Disease," by Israel Diamond, M.D., Louisville.

"Epidemic Diarrhea of the Newborn," Alex J. Steigman, M.D., and Mary O. Cruise, M.D., Louisville.

"Results of Vagotomy and Pyloroplasty," Howard E. Dorton, M.D., Lexington.

"Local Anesthesia for Somatic Tissue," R. W. Augustine, M.D., Madisonville.

"Mental Illness in the Aged," Harold L. McPheeters, M.D., Louisville.

"Accidental Poisoning in Children," William Curtis Adams, M.D., Louisville.

The Rehabilitation Center, Inc., Rex O. McMorris, M.D., Louisville.

CORRECTS MOST TYPES OF CONSTIPATION

Metamucil® Blends with the Intestinal Contents, Soothes the Mucosa



Metamucil is highly refined; it stimulates the bowel musculature, not the mucosa.

When you specify Metamucil in constipation management you are selecting a product which has been made at least 99.6 per cent pure through a complete process of refinement.

All possible irritants (rough parts of the psyllium seed, undesirable oils and similar materials) are discarded during the refining process. A relatively small quantity of purified mucilloid powder is the result. To this is added an equal weight of pure anhydrous dextrose to insure complete dispersion in the colon.

Such meticulous preparation assures that only the bulk-producing mucilloid portion of the psyllium seed remains and that Metamucil will act as a purely "physiologic" constipation corrective, providing bland distention to stimulate the bowel muscularis.

The Metamucil mixture (formed by adding water to Metamucil) elicits gentle colonic reflex peristalsis. Evacuations are normally formed and are not irritating. The bowel stimulation imparted by Metamucil is only sufficient to clear the colon of its contents; patients are not annoyed by the repeated diarrheal evacuations that result from mucosal irritation by drastic cathartics.

The blandness of Metamucil makes it an ideal choice for constipation associated with a soft diet, constipation of pregnancy and in the aged and as an aid in reestablishing normal bowel habit after anorectal surgery. Daily use of Metamucil for a limited time will often return an atonic colon to normal function.

Metamucil® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 1 pound—also 4 ounces and 8 ounces.

G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

SEARLE

"Electrocoagulation of Varicose Veins" Jack Webb, M.D., Lexington.

"Rectal Prolapse," Rufus Alley, M.D., John B. Floyd, M.D., Christopher Southwick, Capt., USAF, Bernard Rosenberg, Capt., USAF, Lexington.

"Hyperparathyroidism: Diagnosis and Therapy," David W. Kinnaird, M.D., Louisville.

"Radioactive Iodine—Its Use in Benign Thyroid Conditions," William H. Hyden, M.D., Lexington.

"Diagnosis of Portal Hypertension," Franklin B. Moosnick, M.D., Lexington.

Southern Medical Association to Celebrate 50th Birthday

The Southern Medical Association will celebrate its Golden Anniversary at the Read House in Chattanooga, Tennessee, October 2 and 3, according to Clayton McCarty, M.D., Louisville, SMA Councilor for Kentucky.

The celebration will begin with a dinner meeting. R. L. Sanders, M.D., Memphis, immediate past president, will be the guest speaker. He will speak on "Fifty Years of Medicine in the South."

The meeting will commemorate the founding of the SMA on October 2-3, 1906, when a group of physicians met at the same Read House and adopted their Constitution and By-laws. On Wednesday, October 3, a plaque will be hung in the Read House. The historical and inspirational meeting will not conflict with the scientific session in Washington, November 12-15.

Room Assignments for Meeting Announced by Dr. Gaither

Room assignments for the specialty groups meeting simultaneously during the Wednesday afternoon session (September 19) of the 1956 Annual Meeting have been announced by Gant Gaither, M.D., Hopkinsville, KSMA President.

Following are the assignments:

Kentucky Society of Anesthesiologists — First Christian Church, Young People's Lounge, Second Floor.

Kentucky Chapter, American College of Chest Physicians, First Christian Church, Forum Classrooms, Second Floor.

Kentucky Eye, Ear, Nose and Throat Society—Columbia Auditorium, Reference Committee Rooms.

Kentucky Academy of General Practice—Columbia Auditorium, Main Auditorium.

Kentucky Obstetrical and Gynecologic Soceity—Calvary Episcopal Church, Sunday School Assembly Room.

Kentucky Orthopedic Society—Calvary Episcopal Church, Visual Aids Room.

Kentucky Chapter, American Academy of Pediatrics—First Christian Church, Downstairs Assembly Room.

Kentucky Chapter, American College of Physicians —Columbia Auditorium, Basement Lounge.

Kentucky Psychiatric Association—First Christian Church, Main Floor Sunday School Assembly Room.

Kentucky Radiological Society—First Christian Church, Lydia Powell Room, Second Floor.

Kentucky Chapter, American College of Surgeons —Columbia Auditorium, Ballroom.

Kentucky Association of Public Health Physicians —Columbia Auditorium. TV Room.

"...in patients with moderately severe and severe cardiac failure, neohydrin is the oral diuretic of choice."*

*Moyer, J. H., and others: J. Chronic Dis. 2:670, 1955.

03056



"the most critical inspection yet devised for an eye-glass lens"--

Your prescription filled by us will be processed to the prescription with first quality materials; the glass and surfaces will be tested for precision of workmanship—and your lenses checked for accuracy of power —only a perfect lens passes the Southern Optical test.



CONTACT LENSES
(Fluidless Lacrilens—Microlens)

Southern Optical COMPANY

ARTIFICIAL EYES
(Custom Plastic—Glass)

HOME OWNED SINCE 1897

4th and Chestnut
334 W. Broadway
LOUISVILLE

GUILD OPTICIANS

New Liberty Doctor Honored

George Purdy, M.D., New Liberty, physician in Owen County for 52 years, was named 'Owen Countian of the Year for 1956' at the recent county fair.

Dr. Purdy was graduated from the Kentucky Medical School in 1904 and opened his office in New Liberty immediately following graduation. Another county physician, J. H. Crisman, M.D., Owenton, won the award in 1954.

UL Alumni to Meet at SMA

Members and friends of the Alumni Association of the University of Louisville School of Medicine who will be in Washington, D. C. for the annual meeting of the Southern Medical Association, November 12-15, are invited to a cocktail party and banquet at the Statler Hotel.

Both social affairs are to be held on Tuesday, November 13, in the Pan American Room. The cocktail party is at 6:30, followed by the banquet at 7:00 PM. According to A. Clayton McCarty, M.D., SMA councilor for Kentucky, no formal program has been arranged. Good fellowship and congeniality will prevail. Tickets may be purchased at the general registration desk.

Postdoctoral fellowships are available, the National Foundation for Infantile Paralysis announces, in preparation for careers in research or academic medicine, clinical psychiatry, rehabilitation, orthopedics, and management of poliomyelitis and preventive medicine. A fellowship committee will recommend the award for which application may be submitted at any time. Applications received on or before December 1 will be considered in February.

Expenses for Refresher Courses Deductible from Income Tax

Physician's expenditures for education are now deductible from their income taxes if they are for a 'refresher' or similar type of course taken to maintain the skills directly and immediately required in the physician's employment or business, according to a letter from George Lull, M.D., Secretary of the AMA.

Dr. Lull further stated that when a physician travels away from home to take a refresher course his travel, meals and lodgings expenses are deductible. His personal expenses, such as sightseeing and social entertaining are not.

Expenses for education designed to prepare the practitioner to enter a specialty are not deductible, Dr. Lull said.

MDs Named Morehead Regents

William H. Cartmell, M.D., Maysville, and Paul Hall, M.D., Paintsville, have been appointed by Governor Chandler to serve as regents of Morehead State College.

Dr. Cartmell, staff member of Hayswood Hospital at Maysville, formerly served as president of the Mason County Medical Society and the Licking Valley Medical Association. He received his medical training at Rush Medical School at the University of Chicago. Dr. Hall, a member of the Southeastern Surgical Congress, formerly served on the KSMA Council. He is a graduate of the Medical Department of the University of Louisville.

64 Technical Exhibitors to Display Products at '56 Annual Meeting

Sixty-four technical exhibitors will display their latest developments in drugs, services, literature and equipment at the 1956 Annual Meeting, September 18-20, according to W. O. Johnson, M.D., chairman of the Committee on Technical Exhibits.

"We appreciate the support these companies give our Annual Meeting. Their exhibits show the latest developments in drugs, services, literature, etc. We are grateful for the important contributions these companies make each year," Dr. Johnson said.

The 1956 exhibitors are:

Abbott Laboratories
A. S. Aloe Company
Ames Company
Ayerst Laboratories
Baker Laboratories
Blue Cross Hospital Plan
Burroughs Wellcome
Burton Parsons & Company
Carroll-Dunham-Smith Co.
Central Pharmacal Co.
Ciba Pharmaceutical Company
Coca Cola Company
Crocker-Fels Company
Dick X-Ray Company
Doho Chemical Corp.
Eaton Laboratories
Encyclopedia Americana
C. B. Fleet Company
General Electric Co., X-Ray
Guild of Prescription Opticians of Kentucky
John Hancock
Health Insurance Council
Hoffman LaRoche
Kay Surgical
Lanier Company
Lederle Laboratories
Eli Lilly and Company
J. B. Lippincott
Logan Company (Sealy)
J. C. Majors, Company
Maltbie Laboratories
Massengill Company
McNeil Laboratories
Mead-Johnson Company
Medical Aids, Inc.
Medical Protective Company
William S. Merrell
Miller Surgical Company
C. V. Mosby
Nordmarck
Ortho Pharmaceutical Co.
Parke-Davis and Company
Pfizer Laboratories
R. J. Reynolds Tobacco Co.
A. H. Robins
J. B. Roerig, Co.
Ross Laboratories (M&H)
Sanborn Company
Sandoz
Schering Corporation

MONODRAL® WITH MEBARAL®



ANTICHOLINERGIC • SEDATIVE

in peptic ulcer management

- **relieves pain promptly**
- **reduces tension safely**
- **tranquilizes without dulling**
- **well tolerated**
- **promotes healing**
- **maintains anacidity for hours**
- **controls hyperactivity of upper gastro-intestinal tract**

MONODRAL with MEBARAL—the "psychovisceral stabilizer"—provides for patients with ulcer and gastro-intestinal spasm an effective barrier against the impact of environmental stimuli . . . controls gastric hypersecretion and hypermotility for three and one half to five hours.*

EACH TABLET CONTAINS:
MONODRAL bromide..... 5 mg.
MEBARAL.....32 mg.

DOSAGE: 1 or 2 tablets three or four times daily.
Available on prescription only.
Bottles of 100 tablets.

Winthrop Laboratories New York 18, N. Y.

Monodral (brand of penthienate) and Mebaral (brand of mephobarbital), trademarks reg. U. S. Pat. Off.
References and clinical trial supplies available on request.



Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

C I B A
Summit, N. J.

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

2/222BM

Julius Schmid, Inc.
G. D. Searle, Company
Sharpe and Dohme
Smith, Kline & French Labs.
E. R. Squibb, Company
Theo Tafel
Templer-Thelan X-Ray
True Fit
United States Tobacco Co.
Upjohn Company
U. S. Vitamin
Warner-Chilcott Laboratories
White Laboratories
Max Wocher

Sears-Roebuck Foundation Announces New MD Loans

The Sears-Roebuck Foundation recently announced its assistance in establishing 11 new medical practices through 13 loans to physicians. The loans, totaling $71,000, were under the Foundation's recently established Plan of Assistance.

The Plan's purpose, according to Theodore V. Houser, president of the Foundation, is to help physicians to supplement this personal and local financing when it is insufficient, especially in areas with inadequate medical care. Mr. Houser announced that applications are being received for loans from an approximate $80,000 available for the last half of 1956.

It was noted by KSMA officials that no Kentucky physicians have applied for these loans to date.

SMA's First Service Award to be Presented in 1956

The Southern Medical Association recently announced the establishment of its Distinguished Service Award. The Award, symbolized by a 14K gold medal, will be presented at the association's Golden Anniversary Meeting in Washington, D. C., November 12-14, 1956.

The award, created at the 1955 meeting, was established "for the purpose of recognizing a physician-member of the Southern Medical Association for outstanding contributions to the advancement of Medicine."

Any member of the SMA in good standing is eligible for nomination. Official nomination forms are available at the SMA headquarters office. Contact the Executive Secretary of the Association, Room 1020, Empire Building, Birmingham 3, Alabama, for further information.

Austin Named Head of Pharmacists

Roy Austin, Paducah pharmacist for 33 years, was elected president of the Kentucky Pharmaceutical Association on August 8. He succeeds Fred L. Lewis, Jr. of Harlan.

The veteran Paducah druggist and five other officers were installed at the closing session of the three-day annual pharmaceutical convention held in Louisville August 5-8. The other officers include: Arthur Reeb, Louisville, first vice-president; J. J. Thompson, Park Hills, second vice-president; R. W. Leake, Danville, third vice-president; E. M. Josey, Frankfort, secretary; and J. P. Arnold, Franklin, treasurer.

Patient's Hospital Expenditures Increase 116% in 10 Years

"In US hospitals of all types, expenditures per patient day rose 116 per cent in the last 10 years, and in the nonprofit short-term general hospitals the rise was 141 per cent," according to Ray E. Brown, president of the American Hospital Association.

Mr. Brown said, "Hospital care has become more expensive as it has offered more diversified services for treating and caring for patients."

Other 10 year trends were pointed out by Mr. Brown. Some were: The over-all increase in the number of hospital beds was 12 per cent. There were 5,397,919 more admissions in 1955 than in 1946—34 per cent increase. In 1955 there was a 63 per cent increase in hospital births. The total number of full-time personnel employed in hospitals of all types rose from 829,571 to 1,300,733.

Louisville MDs Receive Award

The first annual Barr award for the most notable literary contribution in the field of psychiatry and mental hygiene has been received by Harold L. McPheeters, M.D., and W. Walter Fox, M.D., both of Louisville. The presentation was made by Spafford Ackerly, M.D., chairman of the department of psychiatry and mental health at the University of Louisville School of Medicine.

Established in 1954 by the John W. Barr, Jr., Estate Fund, the $100 award will be given each year for literary achievement to a member or members of the psychiatry and mental health department. Research for the McPheeters-Fox paper was done at Central State Hospital, Lakeland.

News Items

The fall meeting of the Midwest Group of the Medical Library Association will be held at Henry Ford Hospital, Detroit, Michigan, on October 19-20, according to David A. Kronick, chairman, Membership Committee. Program topics include: "Medical Writing," "Intravenous Feeding of Whole Food" and "Arabic Medicine." A library workshop is also planned.

M. Harper Wright, MD., an Obstetrican and gynecologist, has become associated with the Graves Gilbert Clinic in Bowling Green. A 1947 graduate of Vanderbilt University School of Medicine, Dr. Wright interned at the Baroness Erlanger Hospital in Chattanooga, Tennessee. He served a residency at the Louisville General Hospital.

Louis D. Myre, M.D., has located in Paducah. A '52 graduate of Northwestern University School of Medicine, Dr. Myre interned at Chicago Wesley Memorial Hospital.

David W. Parsons, M.D., has joined the staff of the Trover Clinic in Madisonville. Dr. Parsons, an internist, was graduated from the Harvard Medical School. He had his hospital training at the Presbyterian Hospital in Chicago and the Hospitals of the University of Pennsylvania.

William Pingelton, M.D., an obstetrician and gynecologist, has begun a practice in Louisville. A 1952 graduate of the North Western University School of Medicine, interned at Parkland Hospital in Dallas, Texas. He served residencies at the University Hospital in Little Rock, Arkansas and the Louisville General Hospital.

OCULISTS' PRESCRIPTIONS EXCLUSIVELY

MUTH OPTICAL COMPANY

Prescription Opticians

665 S. 4th Brown Hotel Building Louisville 2

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Clearview
On The Kratzville Road
EVANSVILLE, IND.

TELEPHONE 5-6181
A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.
SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery
ELECTROENCEPHALOGRAPH — CLINICAL LABORATORY—EKG AND BMR EQUIPMENT—STEREOSCOPIC X-RAY — HYDROTHERAPY.
ALBERT J. CREVELLO, M.D.
Diplomate, American Board of Psychiatry & Neurology, Inc.
MEDICAL DIRECTOR

CROCKER-FELS COMPANY
SERVING PHYSICIANS AND HOSPITALS SINCE 1882



If you're looking for an unusually attractive examining room suite, unusually serviceable equipment, and special features to make your work easier—you'll find them in Hamilton's Steeltone, shown above. And it's available in an array of decorators' colors: white deluxe, cream white, jade green, washington blue, coral, and silver metallic.

The name Hamilton is synonymous with quality.

The Crocker-Fels Company

624 S. THIRD ST. CLay 8855 LOUISVILLE, KY.

Ask about our liberal financing plan

Theodore Koss, M.D., a 1941 graduate of the University of Buffalo (New York) School of Medicine, has located in Paducah. Dr. Koss interned at the Allied Hospitals of the Sisters of Charity in Buffalo.

Charles Taylor, M.D., recently announced his association with **W. M. Brown, M.D.,** and **Grace Brown, M.D.,** in the practice of general medicine in Corbin. Dr. Taylor who interned at the Good Samaritan Hospital in Lexington is a 1955 graduate of the University of Louisville School of Medicine.

Harold Davis, M.D., has begun a residency in radiology at the Louisville General Hospital. Dr. Davis, a '52 graduate of the University of Louisville School of Medicine, formerly practiced medicine in Richmond.

Benjamin Bradford, M.D., an internist, has begun a practice in Paducah. A 1948 graduate of the Louisiana State University School of Medicine, Dr. Bradford interned at the USPHS Hospital in Stapleton, New York. He received his other hospital training at Navy hospitals and Tulane University Hospitals.

D. B. Southard, M.D., retired June 30 as consultant of the Lincoln County Health Department. Dr. Southard, who helped found the department, in 1930, is a graduate of the Hospital College of Medicine. He began his practice in Rockcastle County.

John Berry, Jr., M.D., has become associated with **Robert D. Shepard, M.D.,** Lexington in the practice of radiology. Dr. Berry, a native of Lexington, is a graduate of the University of Louisville School of Medicine. He interned at Good Samaritan Hospital in Lexington. For the past three years he has been serving a residency in radiology at the Louisville General Hospital.

John P. Welborn, M.D., a graduate of the University of Tennessee School of Medicine, has located in Morganfield. Dr. Welborn interned at US Navy Hospitals.

Edward Hand, M.D., has returned from the service and begun a practice in Vine Grove. A '47 graduate of the University of Louisville, Dr. Hand interned at St. Joseph Infirmary in Louisville.

Thomas Ferrell, Jr., M.D., has begun a practice in Elizabethtown. Dr. Ferrell, a '51 graduate of the University of Louisville School of Medicine, formerly practiced in Vine Grove. He interned at St. Joseph Infirmary in Louisville.

Ray Murphey, Jr., M.D., a '52 graduate of the University of Louisville School of Medicine, has begun a practice in Lexington. Dr. Murphey interned at the Good Samaritan Hospital in Lexington and has been associated with the Veterans Administration Hospital in Atlanta.

Hollis Johnson, M.D., has resigned his position with the Norton Infirmary and has entered an association with John P. Bell, M.D., and Harvey S. St. Clair, M.D., Louisville. Dr. Johnson, a psychiatrist, graduated from the University of Louisville School of Medicine and served residencies at the Louisville General Hospital and New York Hospital, Westchester Division, White Plains, N. Y.



Red Davis Sez:

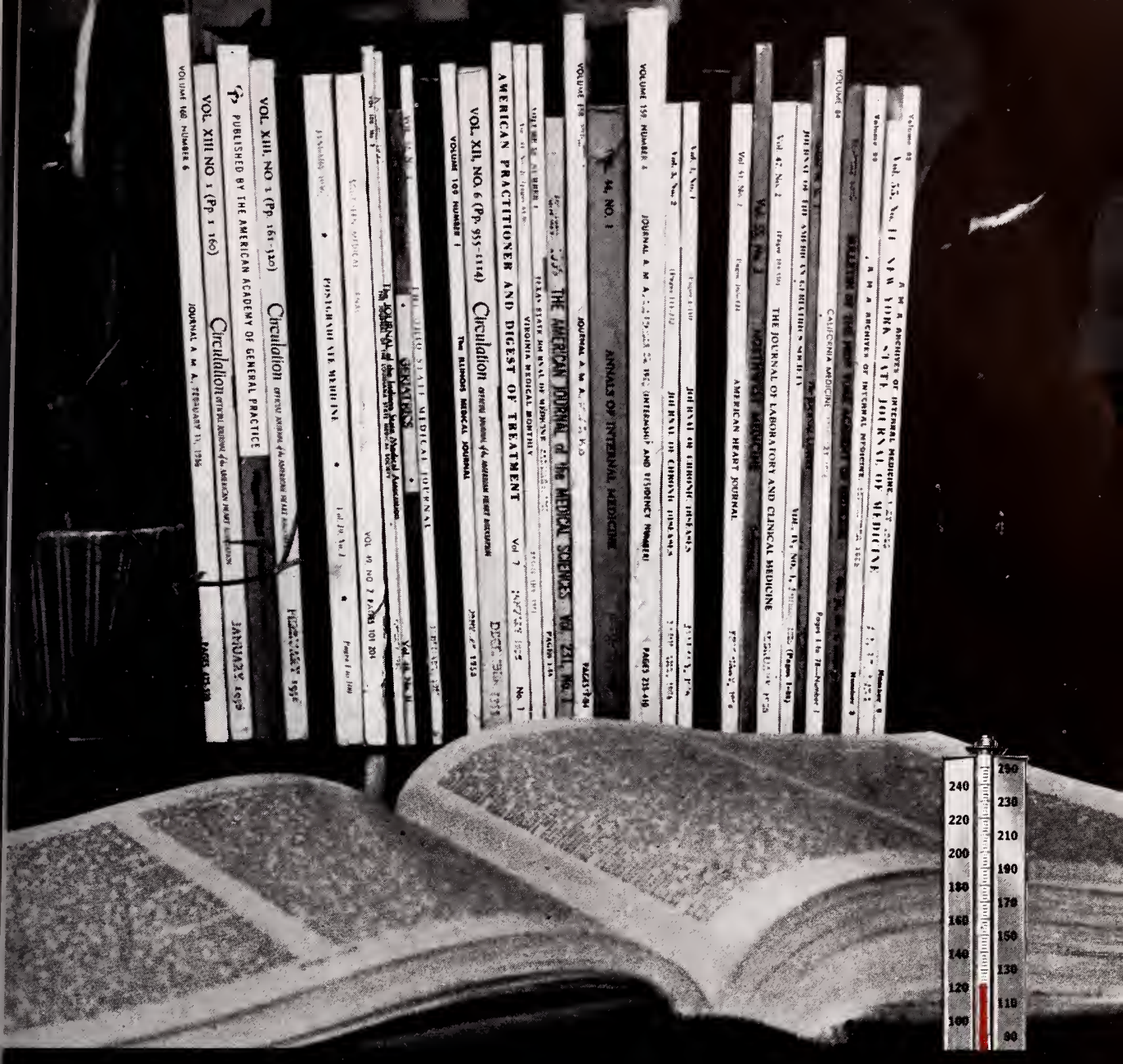
During the State Medical Meeting September 18, 19, 20, I will be in my usual booth in the Exhibit Hall to answer your questions and to render whatever service you may desire in connection with your contract that you have with me and Good ole' John Hancock.

Write or phone
I'll come see you

Phone WA-2632

W. E. "Red" Davis

John Hancock Mutual Life Ins. Co.
507 Marion E. Taylor Bldg.
Louisville, Kentucky



From the Literature

"... the most effective antihypertensive agent available."[1]

"... a simple and safe regimen for the ambulatory management of hypertensive patients."[2]

"... reduction of the blood pressure may be achieved in substantially all forms of hypertension."[3]

"... possible in most patients to get a good control over blood pressure levels with comparatively few side-effects."[4]

"... significant falls ... occurred in systolic and diastolic blood pressure. ... The cardiac, retinal and coronary status of all patients was improved."[5]

1. Maser, M.: New York State J. Med. **55**:1999 (July 15) 1955. 2. Agrest, A., and Haabler, S.W.: J.A.M.A. **157**:999 (March 19) 1955. 3. Smirk, F.H.: Am. J. Med. **17**:839 (Dec.) 1954. 4. Smirk, F.H., and McQueen, E.G.: J. Chron. Dis. 1:516 (May) 1955. 5. Waldman, S., and Pelner, L.: Am. J. M. Sc. **231**:140 (Feb.) 1956.

ANSOLYSEN®

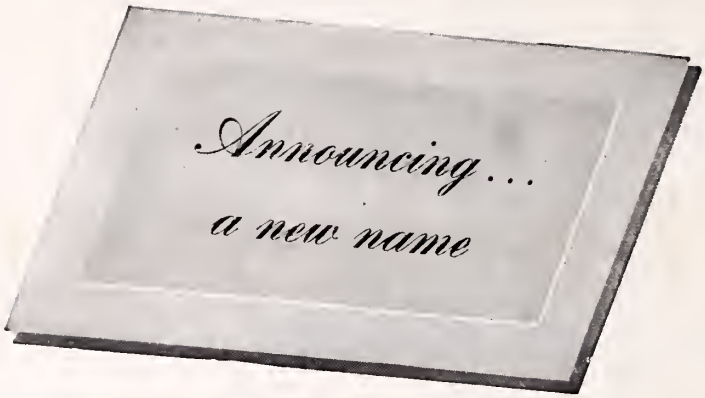
TARTRATE

Pentolinium Tartrate

Lowers Blood Pressure

Wyeth®

Philadelphia 1, Pa.



'LANOXIN'
brand
DIGOXIN

formerly known as Digoxin 'B. W. & Co.'®

The new name has been adopted
to make easier for everyone
the distinction between
Digoxin and Digitoxin.

Now simply write: 'Lanoxin' Tablets 0.25 mg. or 0.5 mg.
'Lanoxin' Elixir Pediatric, or
'Lanoxin' Injection

to provide the unchanging safety and predictability afforded by the uniform potency, uniform absorption, brief latent period and optimum rate of elimination of this crystalline glycoside.

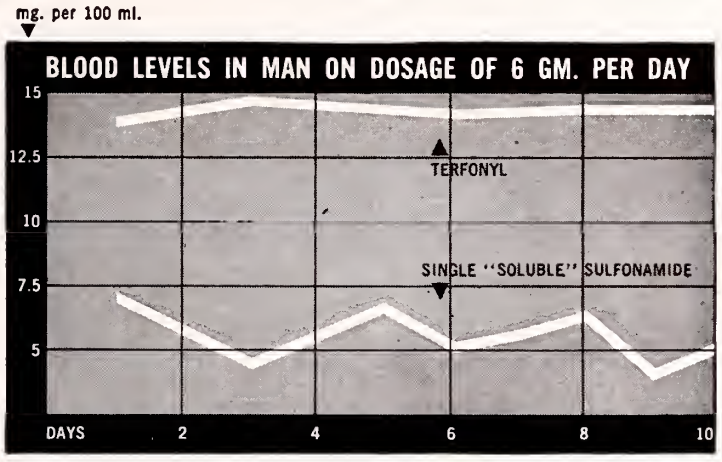
Tablets:	*0.25 mg. (white) and 0.5 mg. (green)*
Elixir Pediatric:	*0.05 mg. in each cc.*
Ampuls:	*0.5 mg. in 2 cc.*

BURROUGHS WELLCOME & CO. (U.S.A.) INC., *Tuckahoe, New York*

maximum efficacy with minimum risk

Terfonyl

SQUIBB METH-DIA-MER SULFONAMIDES



– After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

Terfonyl is absorbed as well as single "soluble" sulfonamides, but is eliminated at a slower rate. For this reason, Terfonyl blood levels are much higher.

In experimental infections (Klebsiella, Pneumococcus, Streptococcus), Meth-Dia-Mer sulfonamides have been shown to be from three to four times more effective on a weight basis than single "soluble" sulfonamides.

Toxicity is minimal because normal dosage provides only one-third the normal amount of each sulfonamide. The body handles each component as though it were present alone, although therapeutic effects are additive.

Terfonyl Tablets, 0.5 Gm., bottles of 100 and 1000.
Terfonyl Suspension, 0.5 Gm. per 5 ml., pint bottles.

0.167 Gm. each of sulfamethazine, sulfadiazine and sulfamerazine per tablet or per 5 ml. teaspoonful of suspension.

SQUIBB

TERFONYL'® IS A SQUIBB TRADEMARK

THE CINCINNATI SANITARIUM

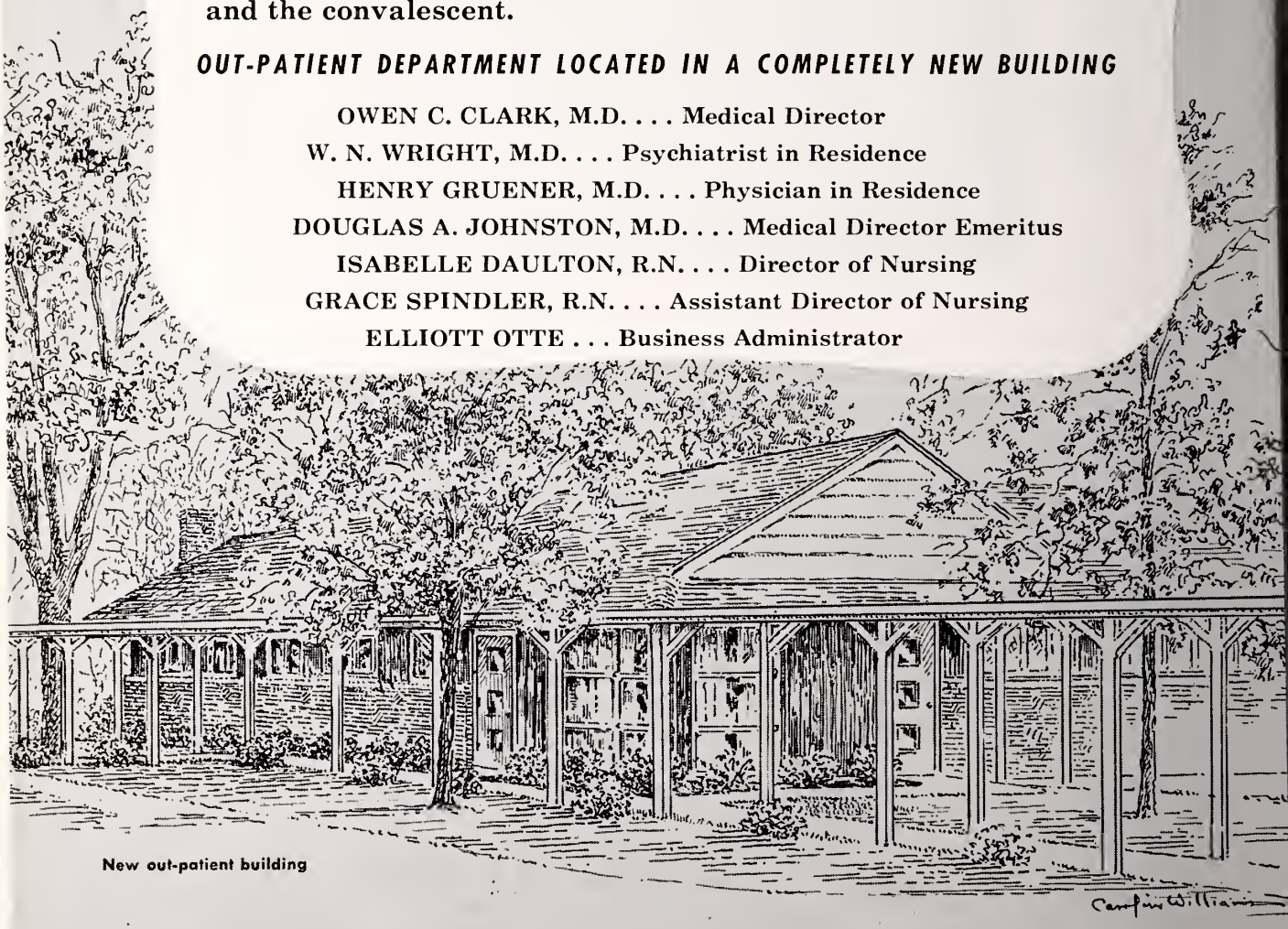
ESTABLISHED 1873

A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
- Ample classification facilities with qualified psychiatric nursing.
- Complete occupational therapy and recreation activities.
- Rest Cottage, a separate department for mild neurotic problems and the convalescent.

OUT-PATIENT DEPARTMENT LOCATED IN A COMPLETELY NEW BUILDING

OWEN C. CLARK, M.D. . . . Medical Director
W. N. WRIGHT, M.D. . . . Psychiatrist in Residence
HENRY GRUENER, M.D. . . . Physician in Residence
DOUGLAS A. JOHNSTON, M.D. . . . Medical Director Emeritus
ISABELLE DAULTON, R.N. . . . Director of Nursing
GRACE SPINDLER, R.N. . . . Assistant Director of Nursing
ELLIOTT OTTE . . . Business Administrator



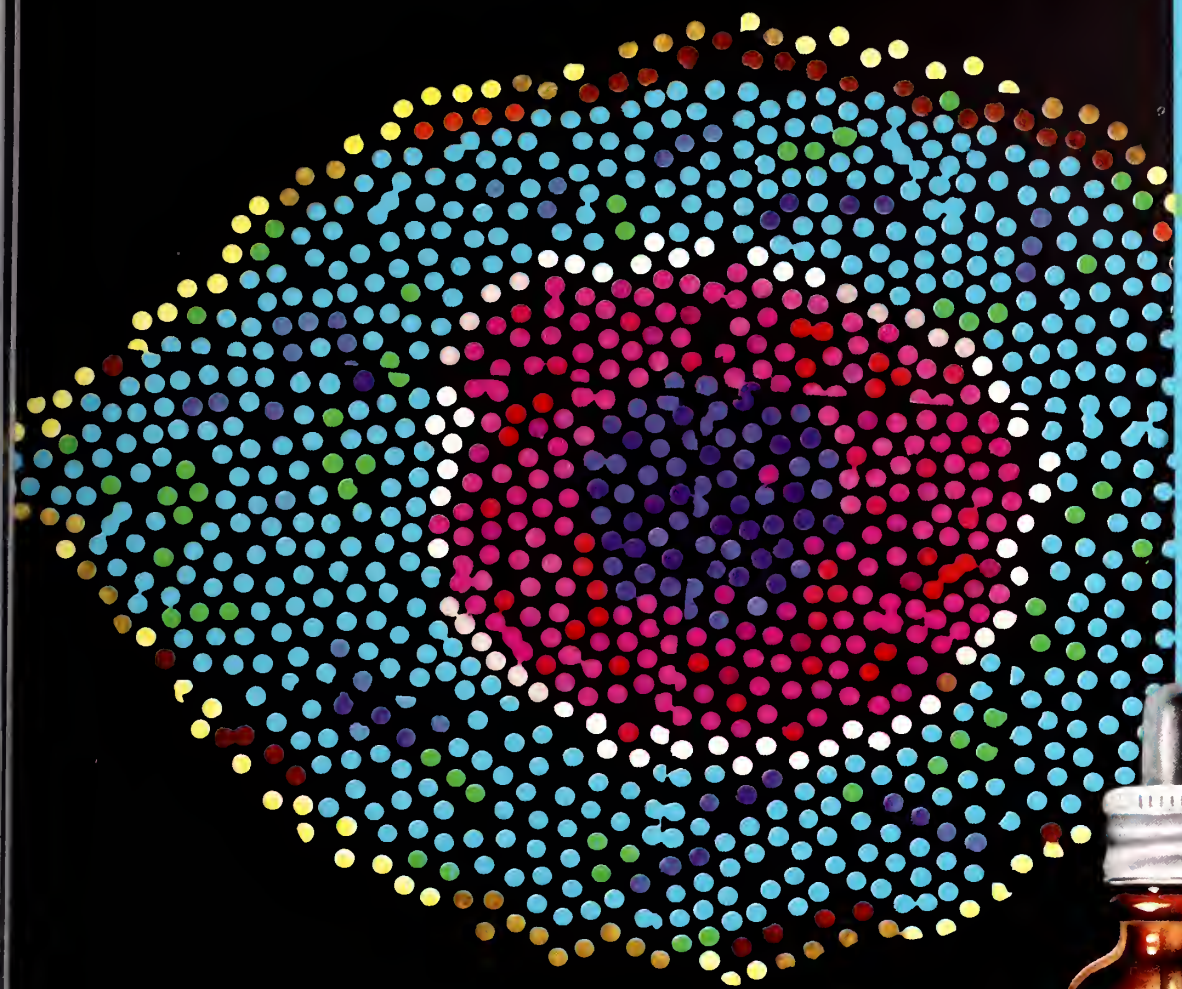
New out-patient building

write for descriptive booklet

THE CINCINNATI SANITARIUM

5642 HAMILTON AVENUE, Cincinnati 24, Ohio

Telephone Klrby 1-0135 Klrby 1-0136





widest approach to eye disorders

combines prednisolone and sulfacetamide
antibacterial
antiallergic
anti-inflammatory

also available as METIMYD Ointment with Neomycin

METIMYD,* brand of prednisolone acetate and sulfacetamide sodium.
*T.M.

MM-J-2-456



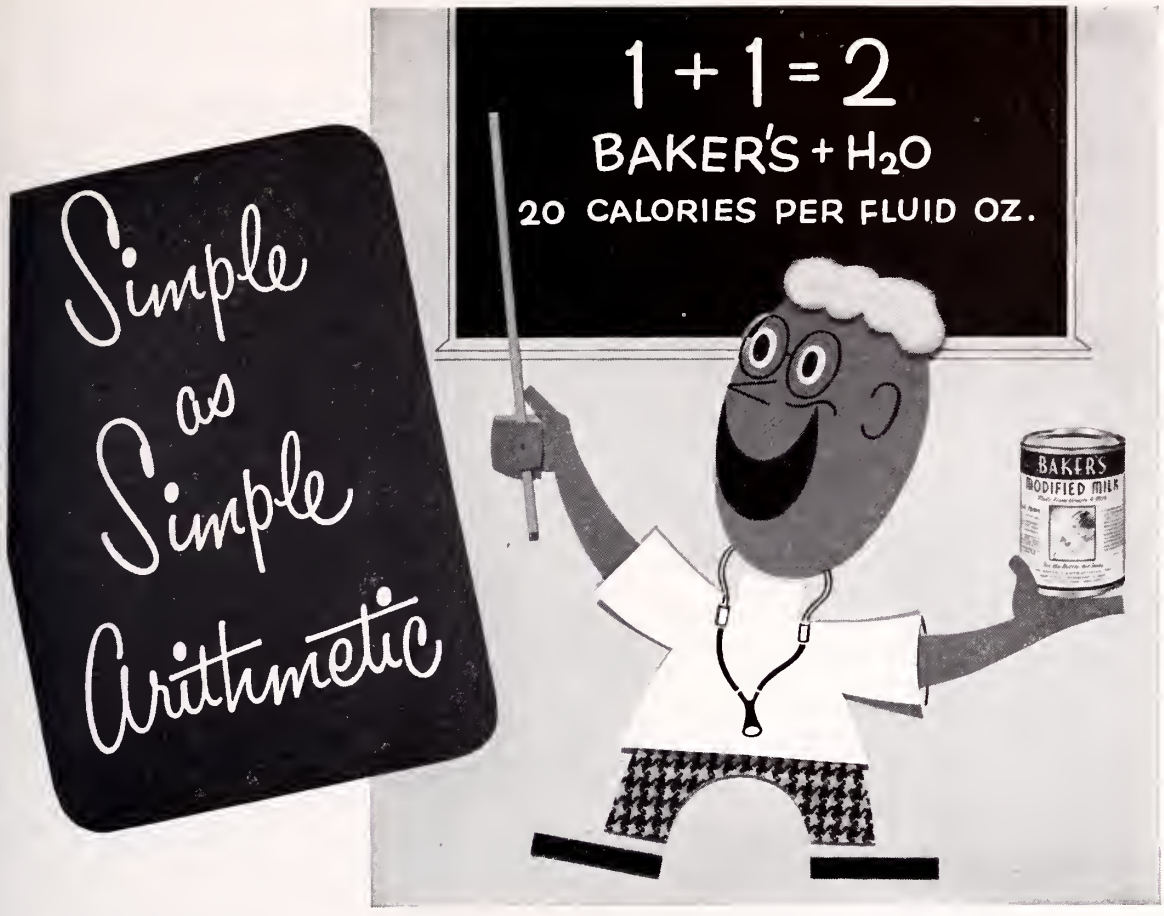
perfect
fusion
for
sharp
focus
in
eye disorders

- infection
- inflammation
- injury
- allergy

Sodium SULAMYD,® brand of Sulfacetamide Sadium U.S.P.
METIMYD,* brand of prednisalane acetate and sulfacetamide sadium.
CORTICLORON,® brand of cartisane acetate and chlorprophenpyridamine preparations.

*T.M.

MM-J-1-456



With little chance of error in Formula Preparation

BAKER'S MODIFIED MILK*

Feeding Directions

Baker's Modified Milk (Liquid)

(Normal dilution for liquid provides 20 calories per liquid ounce.)

	Baker's	Boiled Water
Hospital	1 part	2 parts
First week at home	1 part	1½ parts
After first week at home	1 part	1 part

Also available in powder form. Normal dilution one tablespoon to 2 ounces of water provides 20 calories per fluid ounce.

Designed for all infant feeding from birth to the end of the first year, Baker's Modified Milk is a time-saver for busy physicians and busy hospitals.

Baker's Modified Milk is furnished gratis to all hospitals for your use.

*Made exclusively from Grade A milk (U. S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with vegetable and animal fats and by the addition of carbohydrates, vitamins and iron.

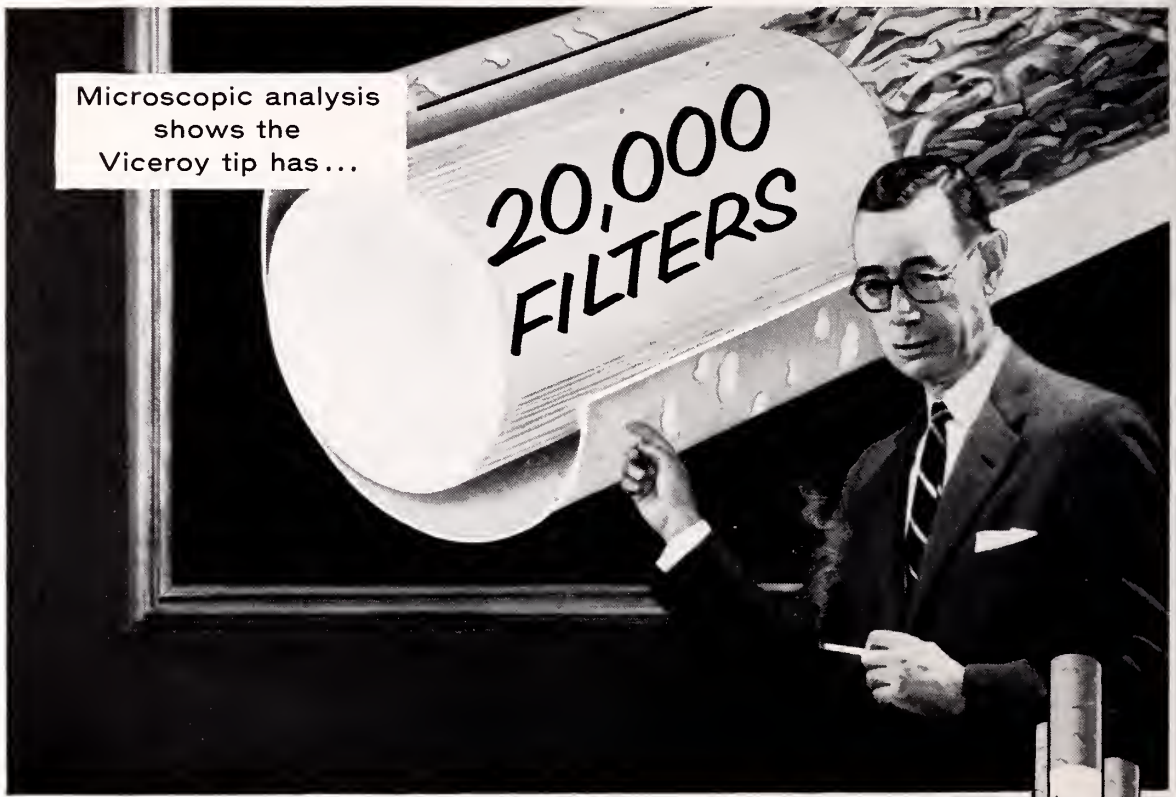
THE BAKER LABORATORIES, INC.

Milk Products Exclusively for the Medical Profession

MAIN OFFICE: CLEVELAND 3, OHIO • PLANT: EAST TROY, WISCONSIN

HERE'S WHY SO MANY DOCTORS NOW SMOKE AND RECOMMEND

VICEROY



Twice as Many Filters

AS THE OTHER TWO LARGEST-SELLING FILTER BRANDS

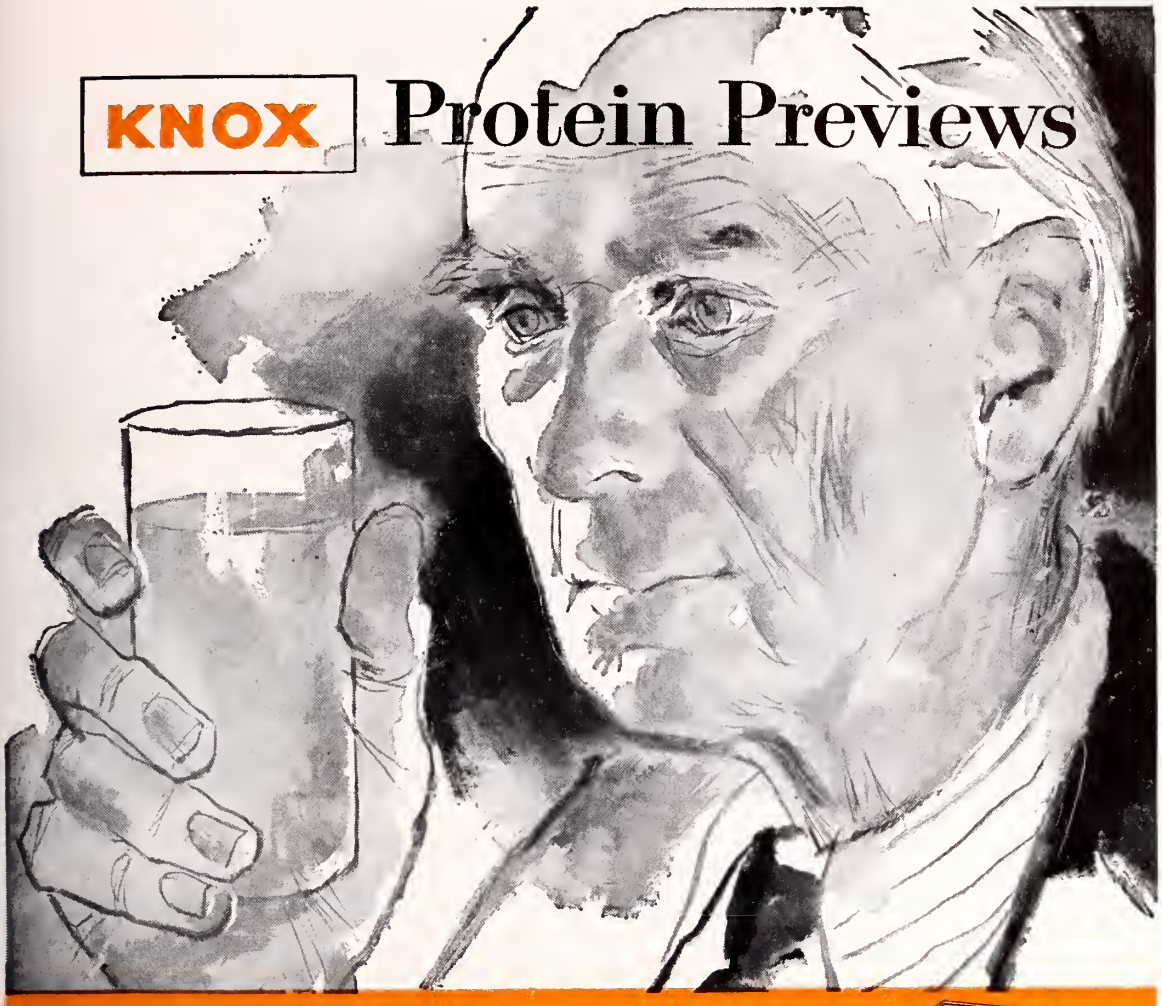
For the Smoothest Taste in Smoking!



VICEROY'S EXCLUSIVE FILTER IS MADE FROM PURE CELLULOSE—SOFT, SNOW-WHITE, NATURAL!



KNOX Protein Previews



Maintaining Lean Body Mass in the Edentulous Geriatric Patient



Extensive loss of body protein can occur in either the spare or obese geriatric patient. But whatever the patient's somatotype, a decrease in lean body mass is usually the result of inadequate protein intake due to poor dentition, slowed-down digestion and quite frequently, unappetizing main dishes.

Knox Gelatine is an excellent non-residue protein which is easy to chew and readily digested and assimilated. As a vehicle for many foods, Knox Gelatine brightens bland diets, giving a new interest to jaded appetites. As a concentrated protein drink, Knox Gelatine supplies seven out of eight essential amino acids and a majority of the other amino acids composing protein.

Specific suggestions on how to use Knox Gelatine in different types of geriatric diets are described in the booklets listed in the coupon below.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Department SJ-18
Johnstown, N. Y.

Indicate number of special diet booklets desired for your patients opposite title:

GERIATRIC_____ REDUCING_____

DIABETIC_____ CONVALESCENT_____

YOUR NAME AND ADDRESS

Relax the best way ... pause for Coke



continuous quality is quality you trust

DRINK Coca-Cola
REG. U.S. PAT. OFF.

organomercurial diuretics "...permit ingestion of enough salt to make food palatable; without them, many patients would lose their appetites, a consequence of the salt-free diet which has occasionally been known to cause serious malnutrition."*

*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

03156

Shoe Last designed to the shape of average normal foot★



- Insole extension and wedge at inner corner of heel where support is most needed.
- The patented orch support construction is guaranteed not to breok down.
- Innersoles guoranteed not to crack or collopse.

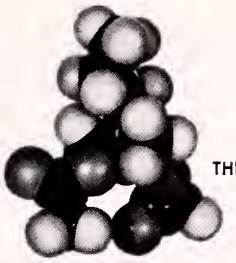
★ Foot-so-Port lasts designed ond the shoe construction engineered with orthopedic advice.

- Canductive Shaes far surgicol ond operating room personnel. N.B.F.U. specifications.
- We are alsa the manufacturer of the Gear-Action Shoe designed by noted orthopedic surgeon.
- We make more shoes for polio, club feet and disabled feet than ony other shoe manufacturer.

Send for free booklet, "The Preservotion of the Function of the Foot Boloncing ond Synchronizing the Shoe with the Foot."

Write for detoils or contoct your locol **FOOT-SO-PORT** *Shoe Agency. Refer to your Clossified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.
A Division of Musebeck Shoe Company



THE MILTOWN MOLECULE

A tranquilizer well suited for prolonged therapy

NO ORGANIC CONTRAINDICATIONS

reported to date

- well tolerated, non-addictive, essentially non-toxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

Indications: anxiety and tension states, muscle spasm.

Miltown®

THE ORIGINAL MEPROBAMATE

DISCOVERED AND INTRODUCED by Wallace Laboratories, New Brunswick, N. J.

2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate—U. S. Patent 2,724,720

SUPPLIED: 400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.

Literature and Samples Available on Request

CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of
mental and nervous disorders, and
addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director

WAYSIDE HOSPITAL

168 North Broadway
Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

APPROVED BY AMERICAN MEDICAL ASSOCIATION

STAFF

H. HALBERT LEET, M.D. JOHN H. ROMPF, M.D.
CARL WIESEL, M.D. IRVING A. GAIL, M.D.
EDWARD L. HOUCHIN, ADMINISTRATOR

Phone: 2-2050

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)
(The Pioneer Postgraduate Medical Institution in America)

PROCTOLOGY and GASTROENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; witnessing operations; ward rounds; demonstration of cases; pathology; radiology; anatomy; operative proctology on the cadaver; attendance at departmental and general conferences.

PRACTICAL ELECTROCARDIOGRAPHY

A two weeks part time elementary course for the practitioner based upon an understanding of electrophysiologic principles. Standard, unipolar and precordial electrocardiography of the normal heart. Bundle branch block, ventricular hypertrophy, and myocardial infarction considered from clinical as well as electrocardiographic viewpoints. Diagnosis of arrhythmias of clinical significance will be emphasized. Attendance at, and participation in, sessions of actual reading of routine hospital electrocardiograms.

For Information about these and other courses Address:

THE DEAN, 345 WEST 50th St., New York 19, N. Y.

. . . part of *every illness*

ANXIETY

is part of

GASTROINTESTINAL DISORDERS



In every patient . . .
a valuable adjunct
to the customary therapy

Supplied: Tablets, 400 mg., bottles of 50.
Usual Dose: 1 tablet, t.i.d.

Wyeth
®
Philadelphia 1, Pa.

*Trademark

Equanil*

MEPROBAMATE
(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)
Licensed under U.S. Patent No. 2,724,720

anti-anxiety factor with muscle-relaxing action

EVERY WOMAN
WHO SUFFERS
IN THE
MENOPAUSE
DESERVES
"PREMARIN"®

widely used
natural, oral
estrogen

AYERST LABORATORIES
New York, N. Y. • Montreal, Canada
5645



the Emblems of RELIABLE PROTECTION

We cordially invite your inquiry
for application for membership
which affords protection against
loss of income from accident and
sickness as well as benefits for
hospital expenses for you and
all your dependents

ALL PREMIUMS COME FROM
PHYSICIANS SURGEONS DENTISTS
ALL BENEFITS GO TO

$4,500,000 ASSETS
$23,800,000 PAID FOR BENEFITS SINCE ORGANIZATION

Since 1902

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

Introducing

A.P.C. WITH Demerol® Tablets

for more efficient

CONTROL OF Pain

Each tablet contains:			
	Aspirin	200 mg.	(3 grains)
	Phenacetin	150 mg.	(2½ grains)
	Caffeine	30 mg.	(½ grain)
	Demerol hydrochloride	30 mg.	(½ grain)

Average Adult Dose: 1 or 2 tablets
repeated in three or four hours as needed.

Bottles of 100 tablets. *Narcotic blank required.*

"Such a combination has proven clinically to be far more effective and no more toxic than equivalent doses of any of these used singly."*

Winthrop LABORATORIES
NEW YORK 18, N. Y.

*Bonica, J.J.; and Backup, P.H.: Northwest Med., 54:22, Jan. 1955.

Demerol, trademark reg. U.S. Pat. Off., brand of meperidine, – May be habit forming

RADIUM

(Including Radium Applicators)

For All Medical Purposes

Est. 1919

Quincy X-Ray & Radium Laboratories

(Owned and Directed by a Physician-Radiologist)

HAROLD SWANBERG, B.S., M.D., Director

W. C. U. Bldg. Quincy, Illinois

WANTED

GENERAL PRACTITIONER
OR INTERNIST

To occupy unit in suite
of downtown Louisville office,
656-660 Francis Building.
Leased by
established Surgeon-Gynecologist.

UNUSUAL OPPORTUNITY!

Phone Ju 4-3614

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465
334 W. BROADWAY
LOUISVILLE, KENTUCKY

WAbash 6725

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**
( ) **Centralized Bookkeeping** (Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Member of the American Hospital Association and National Association of Private Psychiatric Hospitals

Four modern buildings, separate for men and women Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD,
Hospital Administrator

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M.D., Neuropsychiatrist
Medical Director

T. J. SMITH, M.D., Associate



+

B_6

Striking relief from nausea of pregnancy

'MAREDOX'

brand Cyclizine Hydrochloride and
Pyridoxine Hydrochloride

Just one tablet a day, on rising or at night, restores the nausea-free status to most pregnant women.

Each tablet of 'Maredox' contains:
'Marezine'® brand
Cyclizine Hydrochloride . . . . . 50 mg.
Pyridoxine Hydrochloride . . . . . 50 mg.



BURROUGHS WELLCOME & CO. (U. S. A.) INC., Tuckahoe, New York



little

How to win friends ...



The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION of Sterling Drug Inc. 1450 Broadway, New York 18, N. Y.

for preventing and treating upper respiratory infections



new!

Achrocidin*

TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND

ACHROCIDIN provides in one tablet all the drugs which are often prescribed separately for the prevention and treatment of cold complications—conditions such as otitis, adenitis, sinusitis, and others.

This comprehensive formula 1) provides potent therapeutic and prophylactic action against a wide variety of infective organisms, 2) relieves pain and discomfort, 3) depresses fever, 4) alleviates nasal congestion.

Available on prescription only

Each tablet contains:

ACHROMYCIN® Tetracycline.....	125 mg.
Phenacetin.....	120 mg.
Caffeine.....	30 mg.
Salicylamide.....	150 mg.
Chlorothen Citrate.....	25 mg.

Bottle of 24 tablets.

Average adult dose: 2 tablets, 4 times daily

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

*TRADE-MARK

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS—1955-56

Gant Gaither, 109½ East 7th Street, Hopkinsville ..... President
Richard R. Slucher, 2202 Seiger Villa, Louisville ..... President-elect
Clyde C. Sparks, M.D., Mayo Arcade Ashland ..... Immediate Past President
Everett Baker, 408 Brown Bldg., Louisville ..... Vice-President
N. Lewis Bosworth, M.D., 1701 Fincastle Rd., Lexington ..... Vice-President
Howell J. Davis, 330½ Allen, Owensboro ..... Vice-President
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Secretary-Editor Pro tem
Woodford B. Troutman, 1616 Heyburn Bldg., Louisville ..... Treasurer
Charles A. Vance, 271 W. Short Street, Lexington ..... Speaker—House of Delegates
E. W. Jackson, 333 Broadway, Paducah ..... Vice Speaker—House of Delegates
J. Vernon Pace, 709-10 Citizen's Bank Bldg., Paducah ..... Chairman of the Council
Delmas M. Clardy, Hopkinsville ..... Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan	1956
Robertson Joplin, Brown Bldg., Louisville (Alternate)	1956
W. Vinson Pierce, 33 E. Seventh St., Covington	1957
Leon Higdon, 333 Broadway, Paducah, (Alternate)	1957

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Building, Paducah	1956
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1958
Third District	Delmas M. Clardy, Hopkinsville	1956
Fourth District	W. Keith Crume, Bardstown	1956
Fifth District	Carlisle Morse, 3612 Lexington Road, Louisville	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1958
Eighth District	Edward B. Mersch, 92 Arcadia, Covington	1957
Ninth District	J. M. Stevenson, Brookville	1958
Tenth District	J. Farra Van Meter, 183 N. Upper Street, Lexington	1958
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1956
Thirteenth District	Charles B. Johnson, Russell	1958
Fourteenth District	John Archer, Prestonsburg	1956
Fifteenth District	Charles B. Stacy, Pineville	1957

BUYERS GUIDE

JOURNAL OF THE KENTUCKY STATE MEDICAL ASSOCIATION, SEPTEMBER, 1956

Abbott Laboratories 766, 767
American Meat Institute 760
Ames Company, Inc. 827
Ayerst Laboratories 818
Baker Laboratories 811
The Bayer Company 822
Brayton Pharmaceutical Co. 755
George A. Brean & Co. 764
Brown & Williamson Tobacco Co. 812
Burroughs Welcome & Co. 759, 808, 821
Ciba Pharmaceutical Co. 803
Cincinnati Sanitarium 810
City View Sanitarium 816
Clearview Sanitarium 804
The Coca-Cola Company 814
Crocker Fels Co. 805
Fairmount Hospital 826
Foot-So-Port Shoe Co. 814
Geigy Pharmaceutical Co. 765
John Hancock Insurance Co. 806
The Keeley Institute 804
Knox Gelatine Co. 813
Lakeside Laboratories 753, 800, 814
Lederle Laboratories 786, 787, 823
Eli Lilly & Company 770
W. R. Long Insurance Co. 758
Louisville Med. Dental Business Bureau 820
Mrs. Alice Foree Mason (For rent ad) 826
Medical Protective Co. 800
Merck, Sharp & Dohme 750, 751
Muth Optical Company 804
New Castle Sanitarium 826
N. Y. Polyclinic Med. Sch. & Hosp. 816
Parke, Davis & Co. 746, 747
Pfizer Laboratories 763
Physicians Casualty Insurance Co. 818
Pleasant Grove Hospital 820
Quincy X-Ray & Radium Laboratories 820
For rent ad 758
Schering Corporation ..... 2 Inserts
Schering Corporation 754, 768, 769
Clayton L. Scroggins & Associates 826
G. D. Searle & Co. 799
Smith, Kline & French 828
Southern Optical Company 801
E. R. Squibb & Company 809
U. S. Vitamin Corp. 761
Upjohn Company 825
Want Ad (Gen. Practitioner or Internist) 820
Wallace Laboratories 815
Wayside Hospital 816
Winthrop Laboratories 802, 819
Wyeth, Incorporated 749, 756, 757, 807, 817

Upjohn

Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

Cortef* *tablets*

Supplied:

5 mg. tablets in bottles of 50
10 mg. tablets in bottles of 25, 100, 500
20 mg. tablets in bottles of 25, 100, 500

*REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF HYDROCORTISONE (COMPOUND F)

The Upjohn Company, Kalamazoo, Michigan



SECLUSION MATERNITY



FAIRMOUNT HOSPITAL

FOR UNMARRIED GIRLS

Est. 1909

Private sanitarium with certified abstetrician in charge. Folder fully describing services FREE on request. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

Write for Information

HELEN AMOS

4911 East 27th St.

Kansas City, Mo.

Phone: WA. 3-3577

NEW CASTLE SANITARIUM

Telephone 3621

NEW CASTLE, KY.

For the care of

CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the American Hospital Association
Member of the American Assn. of Nursing Homes
Licensed and Approved by the State of Kentucky

SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE

PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS

24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES

New Selectemp Madulated Steam Heat With Filtered Air For Maximum Camfort and Safety

Protected Thraughaut With Autamatic Fire Detectian and Alarm System

IRA O. WALLACE, Administratar

Offices to be put in condition for rent, located 513 Main Street in Shelbyville

Suitable for two young doctors.

Reasonable Rent—Yearly Lease.

Contact: MRS. ALICE FOREE MASON
1101-15th Street N. W.
Apt. 406
Washington, D. C.

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

Tax Returns
Bookkeeping
Delinquent Accounts (No Commission)
Office Routines
Office Planning
Instructing Personnel
Fees
Partnerships
Hospitals
Clinics
Counselling - Investments Insurance

ASSOCIATES:

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hubert G. Stiffler
Daniel L. Zeiser
Richard J. Conklin

Available

PROFESSIONAL BUSINESS MANAGEMENT

FOR DOCTORS ONLY

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945

WOodburn 1-1010

141 West McMillan Street

Cincinnati 19, Ohio

I would like to talk with one of your representatives

Name .....

Address .....

..... Telephone .....

All Services Completely Confidential

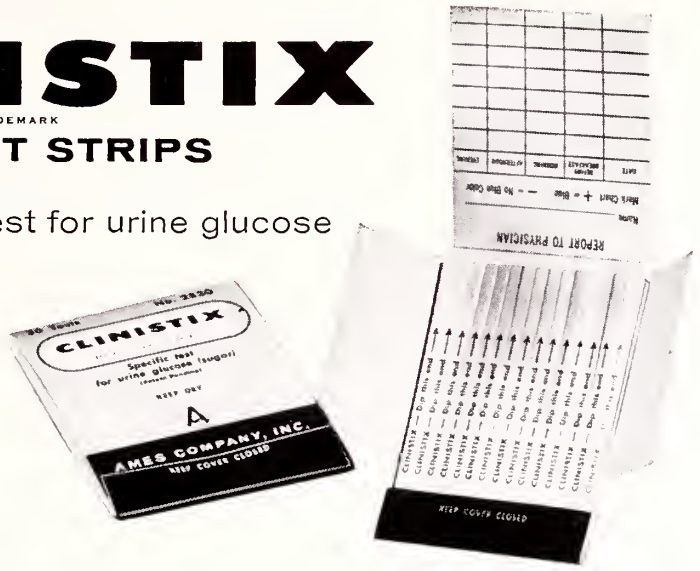
NEW CONCEPT IN URINE-SUGAR TESTING

CLINISTIX

TRADEMARK

REAGENT STRIPS

specific enzyme test for urine glucose



just dip and read



complete specificity ... unaffected by non-glucase reducing substances ... differentiates glucase from ather urine-sugars ... thausands af tests reveal no substance causing a false pasitive.

extreme sensitivity ... detects glucase cancentrations of 0.1% ar less.

utmost simplicity and convenience ... a CLINISTIX Reagent Strip maistened with urine turns blue when glucase is present.

qualitative accuracy ... used whenever presence or absence of glucose must be determined rapidly and frequently. CLINISTIX does nat attempt ta give quantitative results because so many factors in urine influence enzyme reactions.

economy ... CLINISTIX saves time and cuts casts ... each strip is a complete test rapidly perfarmed withaut reagents and equipment.

available: Packets af 30 CLINISTIX Reagent Strips in cartans af 12—No. 2830.

AMES COMPANY, INC • ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

13356



"... a highly effective antiemetic
and is safe for use in children."[1]

THORAZINE* *chlorpromazine, S.K.F.*

The safety and effectiveness of 'Thorazine' for control of vomiting in children has been confirmed by a number of clinicians.

Results in refractory cases have been particularly dramatic.[1-5]

'Thorazine' is available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

'Thorazine' should be administered discriminately; and, before prescribing, the physician should be fully conversant with the available literature.

Pediatric Bibliography

1. Wikler: The Use of Chlorpromazine as an Anti-emetic in Children, Arch. Pediat. *72*:197 (June) 1955.
2. Daeschner et al.: Chlorpromazine in the Control of Vomiting in Children, Am. J. Dis. Child. *89*:525 (May) 1955.
3. Steigman and Vallbona: Chlorpromazine, A Useful Antiemetic in Pediatric Practice, J. Pediat. *46*:296 (March) 1955.
4. Steigman and Vallbona: Experience with Chlorpromazine in Pediatrics, Internat. Rec. Med. & Gen. Pract. Clinics *168*:351 (May) 1955.
5. Moyer et al.: Clinical Studies of an Anti-emetic Agent, Chlorpromazine, Am. J. M. Sc. *228*:174 (Aug.) 1954.

*T.M. Reg. U.S. Pat. Off.

Smith, Kline & French Laboratories, Philadelphia

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION

COLLEGE OF PHYSICIANS
OCT 29 1956
U. OF PHILADELPHIA

In this issue:

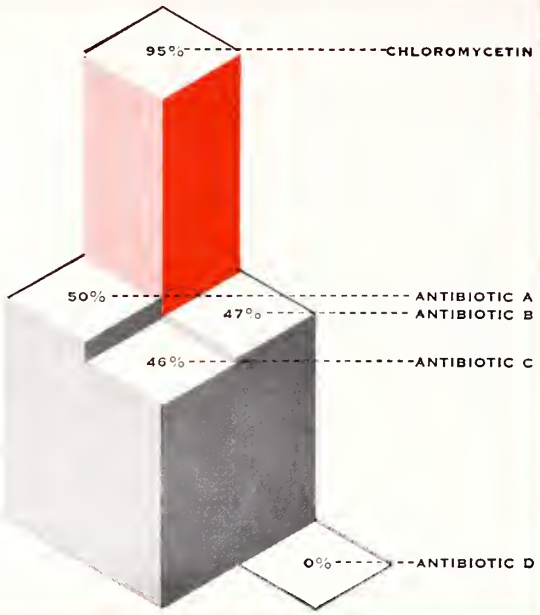
"If I Had An Ulcer"

"Injuries Of The Urinary Tract"

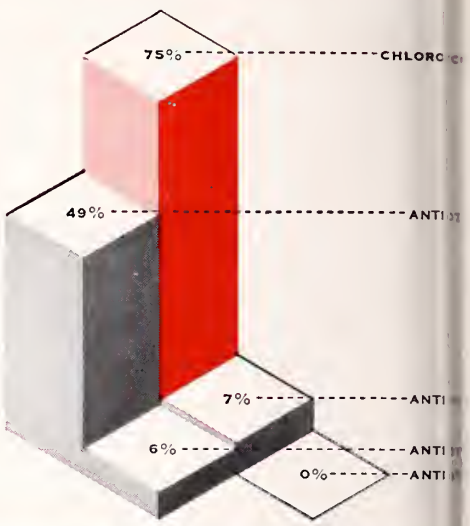
"Modern Concepts In The Treatment Of Goitre"

VOLUME 54 • NUMBER 10 • OCTOBER 1956

SENSITIVITY OF COMMON PATHOGENS TO CHLOROMYCETIN AND FOUR OTHER MAJOR ANTIBIOTIC AGENTS*

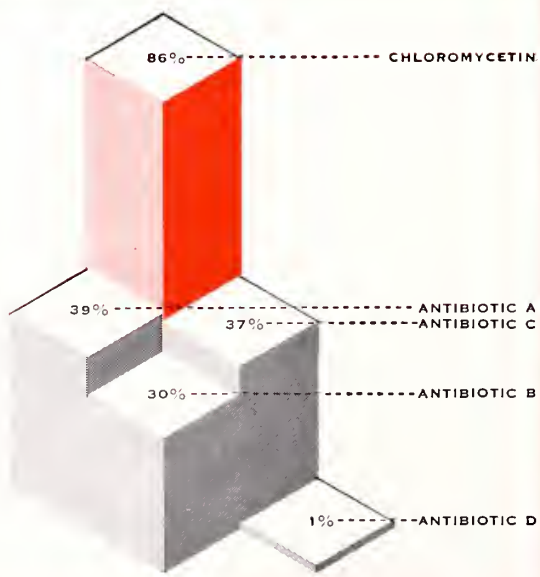


ESCHERICHIA COLI
(148-227 STRAINS)

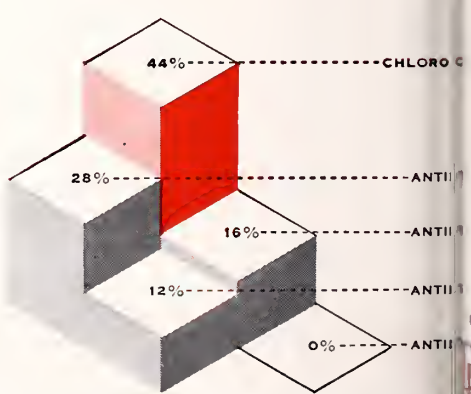


BACILLUS PROTEUS
(63-104 STRAINS)

AEROBACTER AEROGENES
(143-248 STRAINS)



PSEUDOMONAS AERUGINOSA
(39-70 STRAINS)



*This graph, based on *in vitr*
is adapted from Horton and

when more than one organism is involved...

Chloromycetin®

for today's problem pathogens

Therapeutic advantages of CHLOROMYCETIN (chloramphenicol, Parke-Davis) are especially appreciated when mixed infections are encountered because it provides highly effective antibiotic action both against gram-negative and against gram-positive pathogens.[1-7] CHLOROMYCETIN also acts against many pathogens which may grow when originally sensitive organisms have been suppressed.[2]

Unlike some antibacterial agents which are specific for one type of organism only, or others to which bacterial resistance readily develops, CHLOROMYCETIN demonstrates continued efficacy against a wide variety of commonly occurring microorganisms: "Sensitivity of many strains of pathogens to chloramphenicol [CHLOROMYCETIN] and limited tendency of these organisms to develop resistance to this antibiotic explain the effectiveness of chloramphenicol where other antibiotics and chemotherapeutic agents have failed."[1]

CHLOROMYCETIN is a potent therapeutic agent, and because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References: (1) Felix, N. S.: *Pediat. Clin. North America* 3:317, 1956. (2) Joron, G. E.; Fowler, A. F.; de Vries, J.; Reid, G., & Mathews, W. H.: *Canad. M. A. J.* 73:956, 1955. (3) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (4) Perry, R. E., Jr.: *North Carolina M. J.* 16:567, 1955. (5) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (6) Murphy, F. D., & Waisbren, B. A., in Murphy, F. D.: Medical Emergencies: Diagnosis and Treatment, ed. 5, Philadelphia, F. A. Davis Company, 1955, p. 557. (7) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305, 1955. (8) Horton, B. F., & Knight, V.: *J. Tennessee M. A.* 48:367, 1955.

PARKE, DAVIS & COMPANY
DETROIT 32, MICHIGAN

50024

The JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR: GUY AUD, M.D.
MANAGING EDITOR: J. P. SANFORD
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D.
CASE DISCUSSIONS EDITOR: J. C. BELL, M. D.
MED. EDITORIAL EDITOR: S. A. OVERSTREET, M. D.
BOOK REVIEW EDITOR: WALTER S. COE, M. D.
ORGANIZATION EDITOR: GAIL M. RANSDELL
PRINTERS: GIBBS-INMAN, LOUISVILLE

ADVISORY COMMITTEE TO THE EDITOR

James E. Hix, M.D. — Richard J. Rust, M.D., Chairman — Francis Massie, M.D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1959	Term Expires July 1, 1958	Term Expires July 1, 1957
Robert E. Buten, M.D.	Harry D. Abell, M.D.	Carey C. Barrett, M.D.
Thomas Crume, Jr., M.D.	Henry B. Asman, M.D.	Joe Bush, M.D.
German P. Dillon, Jr., M.D.	Marion F. Beard, M.D.	Allen E. Grimes, M.D.
Pat Imes, M.D.	Rankin Blount, M.D.	Richard F. Grise, M.D.
Stanley Parks, M.D.	Glenn Bryant, M.D.	Billy Keller, M.D.
William Roland, M.D.	William C. Buschemeyer, M.D.	A. J. Miller, M.D.
Maurice Walsh, M.D.	Richard Elliott, M.D.	Robert Reeves, M.D.
James Ward, M.D.	Douglas Scott, M.D.	Charles R. Yancey, M.D.

Published at 620 S. Third Street, Louisville 2, Kentucky

Subscription $8.00 per year — Single Copy .80

Contents

SCIENTIFIC ARTICLES

INJURIES OF THE URINARY TRACT STRESSING THOSE DUE TO GYNECOLOGICAL SURGERY, George A. Sehlinger, M.D. 855

IMPLANTATION CARCINOMA IN THE INCISION ATTRIBUTABLE TO DESQUAMATED MALIGNANT CELLS, D. P. Hall, M.D. 859

CHANGING CONCEPTS IN THE MANAGEMENT OF ECLAMPSIA WITH SPECIAL EMPHASIS ON HYPOTENSIVE DRUG THERAPY, George G. Greene, M. D. 862

MODERN CONCEPTS IN THE TREATMENT OF GOITRE, W. Carl Kappes, M.D. 866

WHAT WOULD I DO IF I HAD AN ULCER?, Lester R. Dragstedt, M.D. 870

CASE DISCUSSION 874

EDITORIALS

AUXILIARY ACTIVITIES ACCLAIMED 876

WHAT DOES "BLUE SHIELD" MEAN TO YOU? 876

NURSES LOOK AT THE NURSING PROBLEM 877

ORGANIZATION SECTION

Detection Drive Starts Nov. 11 878
A.M.A. Will Meet at Seattle 878
Ky. MDs Fete S.M.A. Birthday 878
1st Annual Blue Shield Forum Held 878
Diabetes Drive Planned in Areas 879
U.S. Pushes Medicare Program 879
Student AMA to Have Column 879
Physicians' Panel Goes on TV 879
Medical Schools Keep Growing 879
Family Funds Need Safeguarding 880
Hospital Plans are Approved 880
Burney Takes PHS Post 880

REGULAR DEPARTMENTS

President's Page 836
News Items 884
In the Books 840
In Memoriam 885
Washington News Digest 846
County Society Reports 884

Second Class Mail privileges authorized at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.



KARO® SYRUP . . . meets the accelerated nutritional requirement of early infancy

The high caloric requirements of infants, coupled with the fact that they have little ability to digest starchy food, are indications for the use of an easily digested carbohydrate milk modifier.

Karo places a minimum demand upon the digestive system during the first weeks of life. Even premature babies thrive on Karo because this easily digested, completely utilized, fluid mixture of dextrins, maltose and dextrose does not induce flatulence, colic, fermentation or allergy.

Karo permits easy adjustment of formula to meet the accelerated nutritional demand during the early months of rapid growth. Mothers will appreciate the ease of making formulas containing Karo, plus its ready availability and economy. Light or dark Karo syrup may be used interchangeably with cow's milk or evaporated milk and water. Each ounce yields 120 calories.



1906 • **50th ANNIVERSARY** • 1956
CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N. Y.

Upjohn

Ulcer protection that lasts all night:

Pamine* BROMIDE

Tablets

Each tablet contains:
Methscopolamine bromide ..... 2.5 mg.

Average dosage (ulcer):
One tablet one-half hour before meals, and 1 to 2 tablets at bedtime.

Supplied: Bottles of 100 and 500 tablets

Syrup

Each 5 cc. (approx. 1 tsp.) contains:
Methscopolamine bromide ..... 1.25 mg.

Dosage:
1 to 2 teaspoonfuls three or four times daily.

Supplied: Bottles of 4 fluidounces

Sterile Solution

Each cc. contains:
Methscopolamine bromide ..... 1 mg.

Dosage:
0.25 to 1.0 mg. (¼ to 1 cc.), at intervals of 6 to 8 hours, subcutaneously or intramuscularly.

Supplied: Vials of 1 cc.

*TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF METHSCOPOLAMINE

The Upjohn Company, Kalamazoo, Michigan

Sedatives
- A.) hypothalamic — Reserpine
- B.) cortical — Mebaral

A.) Indications

1. Emotional instability
2. Anxiety
3. Tension states
   a.) Premenstrual
   b.) Menopausal
   c.) etc.

B.) Treatment - Tranquilize!

℞

Reserpine-Mebaral

Tablets

usual dose: 1 tab. tid.



Winthrop

Each tablet contains
Reserpine - 0.15 mg.
Mebaral® - 30 mg.
(brand of mephobarbital)



message from the President

Valete et valete,
atque ave.

Fellow Members of the Kentucky State Medical Association:

Let me try to tell you what our State Association offers each of us.

First, it is an organization through which we doctors can give an opinion on any subject affecting us or the health of the people of Kentucky.

Second, every member has the protection of the combined opinions of the rest of the group, which in itself is reason enough to belong. Third, it is an organization through which medical knowledge is increased by attendance at the meetings and in reading the Journal. If we fully realized the amount of work that is put into the annual State meeting or into the Journal, we would never miss a meeting or fail to read a Journal.

Fourth, it is a component part of a national organization, the American Medical Association, which speaks for all doctors in the United States. If we don't always agree with some of the policies, we should make our views known to those who are working hard to perfect a better organization.

Did you know that the executive committee of the KSMA Council meets about once every two months for approximately six hours, and that the Council meets around six times a year for about six hours each time? The members work hard to carry on the business of the organization. They leave their practice and drive long distances to attend the meetings.

And we have many others, in addition to members of the Council and the executive committee, who travel just as far and work just as hard for the KSMA—including our delegates to the American Medical Association who represent us at the two annual meetings. No officer or member of any committee of this organization receives any money for his hard work and travel.

Isn't it wonderful to know that we have men who are willing to add to instead of always taking from the organization?

R. R. Slucher

Richard R. Slucher, M.D.



ORAL PENICILLIN FOR *BETTER* AND *MORE CONSISTENT* ABSORPTION

"Because of the better and more consistent absorption of penicillin V from the intestinal tract, it would appear that this type of penicillin is preferable to penicillin G when oral administration is to be used."[1]

1. Martin, W. J., et al.: J.A.M.A. *160*:928 (March 17) 1956.

PEN•VEE•*Oral* and PEN•VEE *Suspension* permit new dependability in oral-penicillin therapy—dependable stability in gastric acid, dependable and optimal absorption in the duodenum. "Not being destroyed by acid in the stomach, as is penicillin G, penicillin V remains available in larger amounts for absorption."[1]

PEN·VEE* *Oral* and *Suspension*

PEN•VEE•*Oral* is Penicillin V, Crystalline (Phenoxymethyl Penicillin)
PEN•VEE *Suspension* is Benzathine Penicillin V Oral Suspension

*Trademark

Wyeth®
Philadelphia 1, Pa

relaxes both the body and the mind

well suited for prolonged therapy

- well tolerated, nonaddictive, essentially nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

Indications: **anxiety and tension states, muscle spasm.**

THE ORIGINAL MEPROBAMATE

Miltown®

Tranquilizer with muscle-relaxant action

DISCOVERED AND INTRODUCED

BY WALLACE LABORATORIES, *New Brunswick, N.J.*

2-methyl-2-n-propyl-1,3-propanediol dicarbomate—U.S. Patent 2,724,720

SUPPLIED: *400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.*

Literature and Samples Available on Request



THE MILTOWN MOLECULE

24-hour control

for the majority of diabetics



GLOBIN INSULIN

'B.W. & CO.'®

a clear solution . . . easy to measure accurately

Discovered by Reiner, Searle, and Lang
in The Wellcome Research Laboratories

BURROUGHS WELLCOME & CO. (U.S.A.) INC. • Tuckahoe 7, New York



IN THE BOOKS



THE MANAGEMENT OF MENSTRUAL DISORDERS. Fluhmann, C. F. W. B. Saunders Company, Philadelphia, 1956. pp. 350.

This book begins with an historical review of the theories and customs regarding menstruation. After the many weird superstitions, some of which have descended in different forms to the present, menstruation was thought to represent a purgation of poisons, later to relieve a plethora of blood, but in the 18th century, menstruation was intimately associated with ovarian function. Pflüger's theory that menstruation was induced by impulses from ovarian nerves was replaced in the 20th century by the knowledge that the endocrine glands play the chief role. The development of modern knowledge is presented in an interesting and complete fashion.

Over half of this book is concerned with the physiology of menstruation, including that of the uterus, ovaries, pituitary gland and hypothalamus, including experimental animals and particularly the human female. The latter chapters deal with the diagnosis and treatment of various disorders, including primary and secondary amenorrhea, menorrhagia, metrorrhagia, dysmenorrhea and the menopause. Reference to the literature is complete, and all viewpoints, in each instance, are discussed. The author then gives his opinions, which, in general, are the best available today.

The newer consideration of the psychogenic cause of irregularities, especially of a large proportion of cases with secondary amenorrhea, is well presented. Much can be accomplished with women "who are disturbed by fears which engender the loss of the menses, and kindly advice regarding day to day problems of thwarted betrothals, illicit sexual practices, mental disharmony, and disproportionate disappointments in life's struggles far transcends the importance of endoctrine 'shots.' The influence of sympathetic encouragement, a frank explanation of the fundamental mechanisms of the menstrual cycle, and the addition of a ray of hope can accomplish a great deal." The author also quotes from Kroger and Freed, "Fortunately, psychogenic amenorrhea is not often caused by too deeply repressed unconscious conflicts, and this disturbance is usually precipitated by thought material that is only pre-consciousness."

In the treatment of metrorrhagia the author emphasizes that curettage is always indicated, except in young girls, to rule out malignancy, and for its therapeutic effect. All methods of treatment and control are discussed, and while progesterone therapy was discussed at length, the clear enunciation of withdrawal bleeding occurring 3 days after progesterone sensitization, and its almost complete control of all cases of purely functional anovulatory bleeding, was stressed less than this reviewer desired.

This is a detailed, well-written, interestingly-presented and up-to-date summary of certain normal and abnormal functions, involving half of the human race.

Laman A. Gray, M.D.

DISEASES OF THE CHEST: by H. Corwin Hinshaw, M.D., and L. Henry Garland, M. B.: published by W. B. Saunders Company, 1956: 685 pages, 634 illustrations on 288 figures: $15.

Although a complete classification of pulmonary diseases has not been decided upon, this volume covers very adequately the pulmonary illnesses most likely to confront the clinician in his daily practice. The rarer primary pulmonary diseases and those considered to be secondary to disease elsewhere are also discussed.

The 685 pages are written in clear language, to the point, yet covering each subject satisfactorily.

The book is well constructed with tables of contents prefacing each chapter. Lists of references are adequate without being lengthy.

The authors open their preface by calling attention to the unparalleled and impressive advances that have occurred in the field of thoracic disorders in recent years brought about by surgical exploration and effecting advances in diagnostic radiology as a result of correlation of roentgenographic findings with fresh surgical pathology.

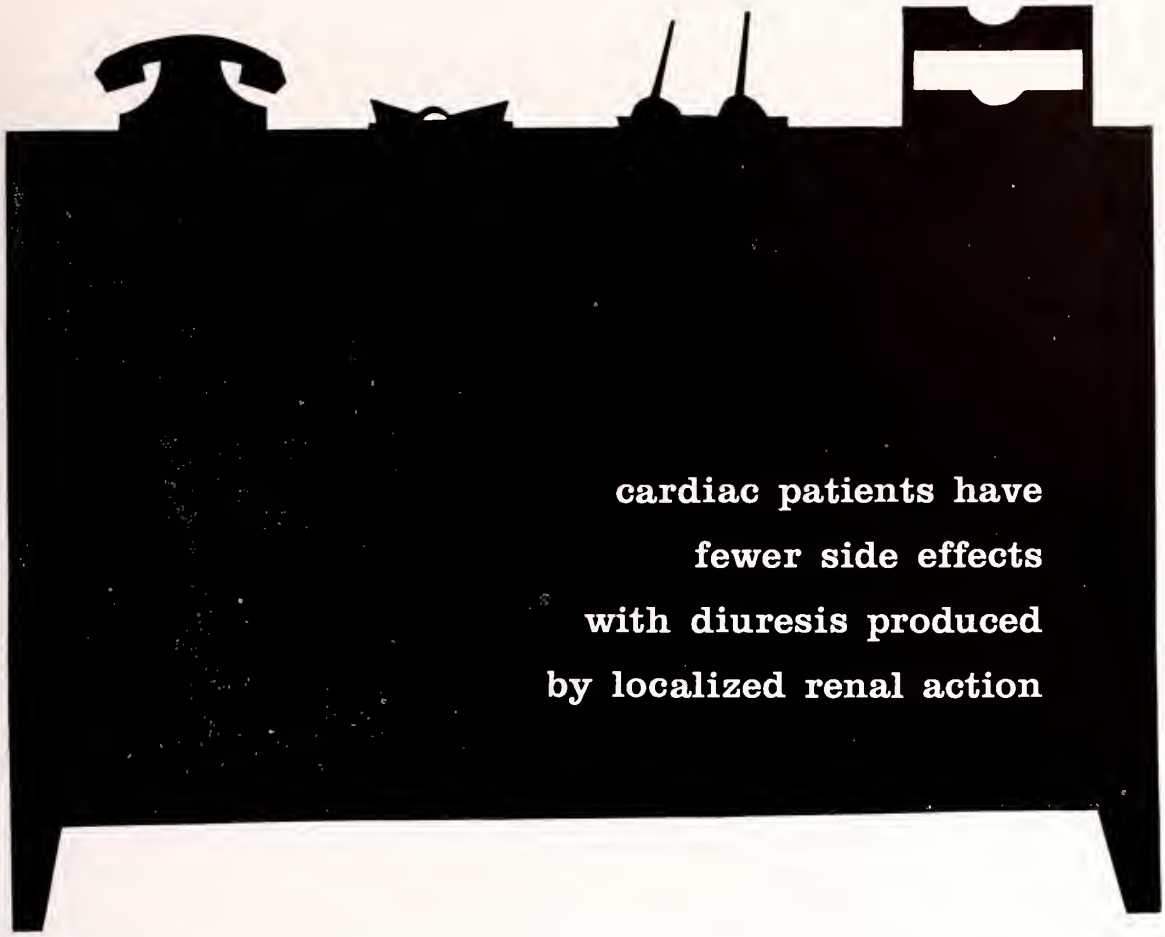
The co-authorship of internist and radiologist further highlights the importance of teamwork between internist, radiologist and thoracic surgeon in the correlation of thoracic complaints.

Emphasis is also made upon the too frequent acceptance of chest roentgenography as a self-sufficient, diagnostic procedure without the consideration of evaluation of symptoms, examination of the patient, and the proper interpretation of laboratory data.

The authors further point out that in thoracic diseases there are more abundant objective data than in other branches of internal medicine where the pathological processes are less available to roentgenological study and where pathways from the site of disease to the exterior are less widely open.

The chapters on evaluation of symptoms, physical examination and diagnostic procedure are presented in orderly fashion. Chapters on bronchogenic carcinoma, pulmonary function, and bronchoscopy are accompanied by excellent illustrations. The latter two and the chapter on coccidiomycosis are written by collaborators.

(Continued on Page 842)



PATIENTS IN FAILURE NEED AN ORGANOMERCURIAL

When acidosis is the diuretic mechanism, as with the carbonic anhydrase inhibitors and acidifying salts, widespread effects on many organs can be anticipated.
In contrast, the dependable diuresis produced by the organomercurials—resulting from enzyme inhibition localized in the kidney—avoids these extrarenal effects.

TABLET

NEOHYDRIN®

BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure

MERCUHYDRIN® SODIUM
BRAND OF MERALLURIDE INJECTION

LAKESIDE

02656

Doctor Disabled

OFFICE EXPENSE CONTINUES

At last, here is the practical solution to this problem - - - an insurance policy to pay your expenses, with the premium eligible as a Tax Deduction.

Latest Tax ruling provides that premiums on Health and Accident insurance are not deductible unless the policy states that it is for the express purpose of meeting business overhead expenses.

Ask your Accountant or Lawyer about this question and then ask us to explain this coverage.

W. R. LONG & ASSOCIATES
1534 Bardstown Road—Louisville, Ky.

Without obligation to me I would like to have more information on your office expense policy. I am in good health and was

born .....
Month Day Year

Name .....

Address .....

In The Books

(Continued from Page 840)

Of the total of forty chapters, seven are given to all aspects of pulmonary tuberculosis and its extrapulmonary manifestations and one to the medical aspects of tuberculosis control. Thoracic injuries, mediastinal, mycotic, parasitic, and occupational diseases, are well covered.

Many of the acute and chronc illnesses confronting the physician in his daily practice are primarily pulmonary diseases or are pulmonary manifestations of disease to be found elsewhere. Routine use of chest radiography often reveals pathological processes unknown to both the patient and physician which require further investigation.

This volume should therefore serve as a valuable guide to both specialist and general practitioner and as a reference book for students and residents.

Alvin B. Mullen, M.D.

DISEASES OF THE SKIN: Richard L. Sutton, Jr., M.D. C. V. Mosby Company—Publisher. St. Louis—1956.

Dr. Sutton has done it again! The eleventh edition of his standard textbook, which has only recently come off the press, is literally crammed full of knowledge and useful information throughout its nearly 1,500 pages.

The index is most extensive, and yet so simplified that even the rarest and most recently described dermatological conditions are easily and quickly located.

The black and white illustrations are for the most part excellent, particularly those in the chapter on pathology, which incidentally is exceptionally well done—practically a manuscript in itself.

The 88 pages on syphilis furnish the student with equally as much information as some of the larger texts. The sections on serologic tests and neurosyphilis were exceptionally well done.

That portion dealing with the history and use of biological and chemical agents will prove most useful as a ready reference and much information is stored in these few pages.

The bibliography, some of the rarer dermatoses, and various tests are wisely handled in fine print. Thus, much additional and useful imformation is always readily available.

The one criticism noted here, as with other American authors of textbooks, is their failure to utilize the French system of loose-leafing their texts. How easily such a book could be kept current. Perhaps, however, this is the fault of the publisher, rather than the author.

In conclusion, this book should be regarded as one essentially for the dermatologist, internist, and rare practitioner of medicine whose interests are particularly dermatologic in character. It is not recommended primarily as a textbook for undergraduate students. Dr. Sutton is therefore urged to continue publishing his "Handbook of Diseases of the Skin."

A. B. Loveman, M.D.

for preventing and treating upper respiratory infections...



Achrocidin*

Tetracycline-Antihistamine-Analgesic Compound

ACHROCIDIN is a comprehensive formula for treatment of complications of the common cold, particularly when bacterial sequelae are observed or expected from the patient's history or during widespread infections.

Distressing symptoms of malaise, headache, muscular pain, mucosal and nasal discharge are rapidly relieved.

And potent prophylaxis is offered against other diseases, such as otitis media, sinusitis, adenitis, and bronchitis, to which the patient may be highly vulnerable at this time.

ACHROCIDIN is convenient for you to prescribe—easy for the patient to take. Average adult dose: two tablets four times daily.

Available on prescription only

Each tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottle of 24 tablets

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N. Y.

*TRADEMARK

"You try to scrub the bathtub with your back aching morning till night!"

"I don't know about bathtubs, but two days ago I couldn't reach a shelf higher than that."

"I thought maybe I slept in a draft. Never had a stiff neck like this before."

"That's nothing. I went around with my arm in a sling for nearly two weeks—had to sleep with a pillow at my back so I wouldn't roll over on it."

"I thought I was getting too old for high heels—low heels didn't help. My leg hurt down to the ankle."

"That's fu
I'm on m
feet all d
but it wa
my arms
bothered



. . . safeguarded relief all the way across th

Prednisone + Acetylsalicylic Acid + Aluminum Hydroxide + Ascorbic Aci

Potent corticosteroid anti-inflammatory action complemented by rap
analgesia; doubly protected with antacid and supplemental vitamin

*T.M. SG-J-486

"My back was so tight I couldn't even get on and off the bus; now I can climb stairs."

"I hope he helps my knee that quick."

"Take it from me, you should be glad you saw him early in the game so he could do some good."

"Good?— why, he's got me doing exercises I haven't done in years."



ɔread of common rheumatic complaints

Summated, protective corticoid-analgesic therapy

SIGMAGEN*

corticoid-analgesic compound tablets

- brings specific, complementary benefits to the treatment of muscle, ligament, tendon, bursa and nerve inflammation
- for the initiation of treatment of milder rheumatic disease
- for continuous or intermittent maintenance in more severe rheumatic involvement

Bottles of 100 and 1000.

Schering



WASHINGTON NEWS DIGEST



Washington, D. C.—Regardless of which party organizes the next Congress or who occupies the White House, health and welfare legislation promises to take up considerable time and attention of lawmakers. There is nothing to indicate that the general subject of health has lost its appeal either to the public in general or to men who run for political office in particular.

The national platforms on which the candidates of both parties have been campaigning are somewhat of a blueprint for the type of legislation to come in the 85th Congress, convening next January 3; generally, both parties advocate more rather than less federal participation in health and welfare programs. Here are some of the points in the two platforms:

Aid to Medical Schools—The Republicans recommend "federal assistance to help build facilities to train more physicians and scientists" as a supplement to action of the 84th Congress authorizing federal grants to schools and other groups for laboratory research facilities. The Democrats state: "We pledge ourselves to initiate programs of federal financial aid, without federal controls, for medical education."

Aids to Hospital Construction—The Republican plank: "Republican leadership has enlarged federal assistance for construction of hospitals." The Democratic plank: "We pledge continuing and increased support for hospital construction programs."

Medical Research—Republicans: "We have asked the largest increase in research funds ever sought in one year to intensify attacks on cancer, mental illness, heart diseases and other dread diseases." Democrats: "We shall continue to support vigorously all efforts, both public and private, to wage relentless war on diseases . . . We commend the Democratic party for its leadership in obtaining greater Congressional authorizations in this field."

Vocational Rehabilitation—Republicans: "We have fully resolved to continue our steady gains in man's unending struggle against disease and disability." Democrats: "We pledge support to a vastly expanded rehabilitation program for these physically handicapped, including increased aid to states."

Medical Care—Republicans: "We have encouraged a notable expansion and improvement of voluntary health insurance, and urge that reinsurance and pooling arrangements be authorized to speed this progress." Democrats: "We pledge . . . increased federal aid to public health services, particularly in rural areas."

Social Security—Republicans: "We shall continue to seek extension and perfection of a sound social security system." Democrats: "By lowering the retirement age for women and for disabled persons, the Democratic 84th Congress pioneered two great advances in social security . . . We shall continue our efforts to broaden and strengthen this program by increasing benefits to keep pace with improving standards of living, by raising the wage base upon which benefits depend and by increasing benefits for each year of covered employment."

NOTES:

Further evidence that federal aid to medical schools will be high on the agenda of the next Congress is the survey underway by the staff of the House Interstate and Foreign Commerce Committee. More than 50 organizations have been sent letters requesting background facts on financial needs of medical schools and the demand for medical school applicants "rather than arguments intended to support or oppose any particular form of federal aid." The information is being gathered as a preliminary to hearings in the next Congress.

Public Health Service announced the availability of 250 traineeship grants for graduate or specialized training of professional public health personnel under the newly enacted Health Amendments (Omnibus) Act. Emphasis is on bringing new and younger people into public health, men and women under 35 years of age. Congress voted one million dollars for the program this year. Another 500 traineeships from a two million dollar appropriation are offered for graduate nurses in administrative, supervisory and teaching positions.

While Defense Department officials were putting the finishing touches on regulations to carry out the military dependents medical care program, the State Department was working on its own version of a program for furnishing care to about 13,500 dependents of Foreign Service personnel stationed overseas. In most instances, medical and hospital care (with a $35 deductible clause) will be supplied in U. S. military installations.

To aid Defense in setting up fee schedules for military dependents using private physicians and facilities, state medical societies in cooperation with the American Medical Association have been asked to supply data on prevailing medical care charges.

New chief of the PHS Communicable Disease Center at Atlanta, Ga., is Robert J. Anderson, M.D., a career PHS officer who has been serving as assistant chief of the division of special health services.

recognized

as a potent, specific anti-arthritic

established

by over 100 million patient days

substantiated

in more than 700 published reports

BUTAZOLIDIN®

(phenylbutazone GEIGY)

potent, specific anti-arthritic

Based on an impressive background of achievement attained over a period of four years involving both long-term and short-term therapy in all the major forms of arthritis, BUTAZOLIDIN is recognized as one of the most effective anti-arthritic agents currently available.

relieves pain

improves function

resolves inflammation

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before prescribing it.

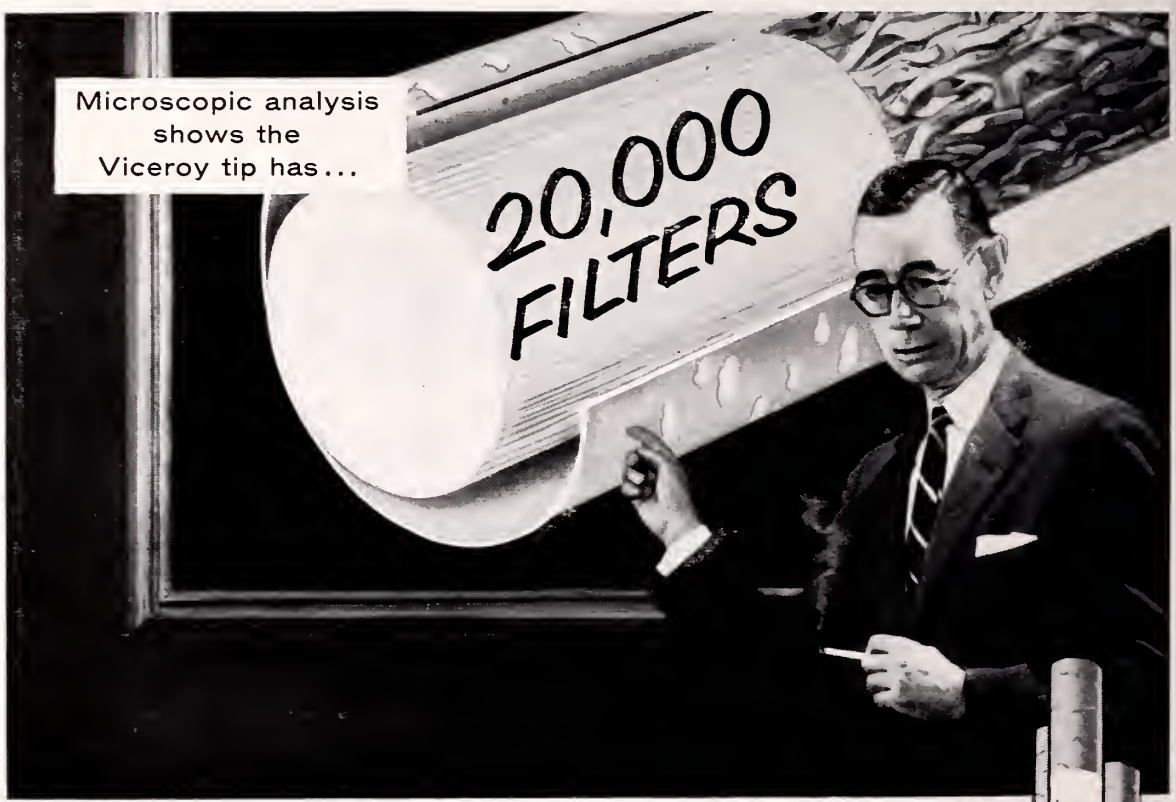
GEIGY

GEIGY PHARMACEUTICALS, Division of Geigy Chemical Corporation, New York 13, N. Y.

72556

HERE'S WHY SO MANY DOCTORS NOW SMOKE AND RECOMMEND

VICEROY



Twice as Many Filters

AS THE OTHER TWO LARGEST-SELLING FILTER BRANDS

For the Smoothest Taste in Smoking!



VICEROY'S EXCLUSIVE FILTER IS MADE FROM PURE CELLULOSE—SOFT, SNOW-WHITE, NATURAL!



New
Evidence
on

Rauwiloid®

confirms and defines superiority over other Rauwolfia preparations in the treatment of HYPERTENSION

- Rauwiloid represents the balanced, mutually potentiated actions[1] of several Rauwolfia alkaloids, of which reserpine and the equally antihypertensive rescinnamine have been isolated.
- Hence, reserpine is not the total active antihypertensive principle of the rauwolfia plant.
- Rauwiloid is freed of the undesirable alkaloids of the whole rauwolfia root. Recent investigations confirm the desirability of Rauwiloid (because of the balanced action of its contained alkaloids) over single alkaloidal preparations; "...mental depression...was...less frequent with alseroxylon..."[2]

The dose-response curve of Rauwiloid is flat, and its dosage is uncomplicated and easy to prescribe...merely two 2 mg. tablets at bedtime.

1. Cronheim, G., and Toekes, I. M.: Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

Riker

LOS ANGELES

Rauwiloid is the original alseroxylon fraction of India-grown Rauwolfia serpentina, Benth., a Riker research development.



Most people are able to talk freely to their physician about every aspect of their treatment—*except one*. The question, "How much is it going to cost?" and of how payment is to be made, often leaves the frankest patient tongue-tied.

Many refrain from bringing up the subject out of a sincere respect for their doctor, supposing it somehow unbecoming to talk to him about money. Many professional societies are now trying to clear up this misconception. For example, you may have noticed a significant plaque which hangs in thousands of physicians' waiting rooms. It says:

"To all my patients—I invite you to discuss frankly with me any questions regarding my services or fees. The best medical service is based on a friendly mutual understanding between doctor and patient."

Sometimes, of course, your doctor cannot tell you, in advance, precisely what a course of treatment or an operation is going to cost. But you will always find him willing to discuss the subject, and to tell you if he can. Today more than ever before in medical history, the bill your doctor sends you can represent one of the really big bargains of your life—in terms of health, happiness and peace of mind.

Copyright 1956—Parke, Davis & Company

PARKE, DAVIS & COMPANY
Research and Manufacturing Laboratories Detroit 32, Michigan

Makers of medicines since 1866



Doctor, you have probably seen one or more of these current Parke-Davis advertisements in leading general magazines—and you know that the much-talked-about theme of these ads is that *prompt and proper medical care is one of today's biggest bargains.* Through our sales representatives who call on you, and your letters to us, we know that this is the type of laity advertising *you* like to see.

The reproduction on the facing page is the latest example of this advertising. It tells the public that they can discuss medical fees with their physicians without embarrassment . . . and that such discussions improve the important relationship between doctor and patient.

We are gratified at your response to these public messages, and you can be sure that Parke-Davis national advertising will continue to be in our *mutual* best interests.

PARKE, DAVIS & COMPANY

Detroit 32, Michigan

Reaching millions of people in LIFE, POST, TODAY'S HEALTH and other leading magazines

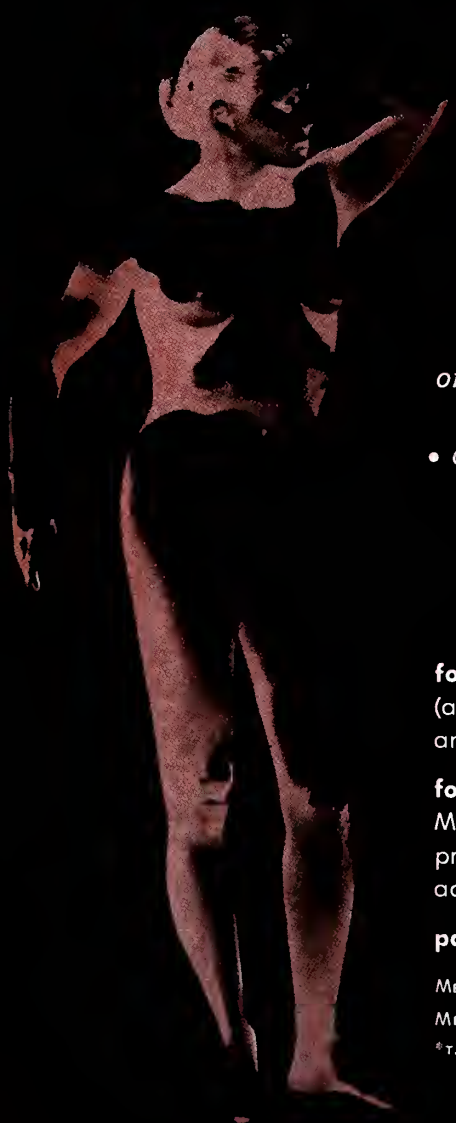


magnified potency
with Meti-steroid
effectiveness in allergic
and inflammatory dermatoses

new

Meti-Derm cream 0.5%

with METICORTELONE, original brand of prednisolone



- *approximately*

twice the per milligram

anti-inflammatory activity

of topical hydrocortisone

- *cosmetically acceptable*
- *water-washable*

for effective local relief of allergic (atopic and contact) dermatoses, nonspecific anogenital pruritus.

formula: Each gram of water-washable METI-DERM Cream contains 5 mg. (0.5%) of prednisolone, free alcohol, in a cosmetically acceptable base.

packaging: METI-DERM Cream, 0.5%, 10 Gm. tube.

METI-DERM,* brand of prednisalane topical.
METICORTELONE,® brand of prednisalane.
*T.M.

...and adding dual control

to Meti-steroid skin therapy—

protection

against infection

new

Meti-Derm ointment

with Neomycin



enhanced effectiveness

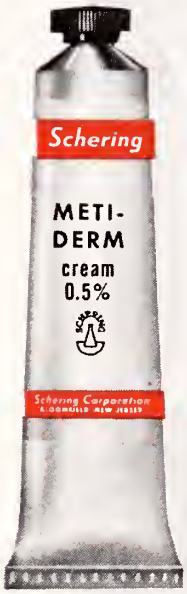
in allergic, inflammatory

dermatoses when

minor infection

is present

or anticipated



neomycin in addition to prednisolone, free alcohol—for protective coverage against virtually all pathogenic skin bacteria with a well-tolerated, *topical* antibiotic.

formula: Each gram of METI-DERM Ointment with Neomycin contains 5 mg. (0.5%) prednisolone, and 5 mg. (0.5%) neomycin sulfate equivalent to 3.5 mg. neomycin base.

packaging: METI-DERM Ointment with Neomycin, 10 Gm. tube.

Schering

MD-J-656



specify

'Merthiolate'

(THIMEROSAL, LILLY)

'Merthiolate' is highly active under virtually all conditions; is relatively nonirritating and nontoxic

'Merthiolate' is germicidal in dilutions up to 1:4,000 in serum media and is relatively nonirritating in the concentrations suggested for use. It also maintains its activity in the presence of soaps. The fact that 'Merthiolate' is used as a bacteriostatic agent in fluids for parenteral administration gives strong evidence of its safety.

80TH ANNIVERSARY 1876 · 1956 / ELI LILLY AND COMPANY

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 OCTOBER, 1956 NO. 10

INJURIES OF THE URINARY TRACT STRESSING THOSE DUE TO GYNECOLOGICAL SURGERY*

GEORGE A. SEHLINGER, M.D., F.A.C.S.
Louisville

INJURIES of the urinary tract may be divided on the basis of etiology into two large categories, surgical and non-surgical. It is the intent of this discussion to stress the surgical injuries; however, it would seem proper, in view of the ever increasing importance of trauma, to comment very briefly on some aspects of the non-surgical injuries.

Kidney Injury

The management of the closed or non-penetrating injury of the kidney is a controversial subject. Some authorities advocate observation while others demand surgical exploration. Logical treatment must be determined by careful clinical evaluation. The indications for surgical intervention are mainly: (1) critical hemorrhage for which surgery may be life saving and which usually requires nephrectomy, (2) extravasation of urine, in which surgery is directed toward conserving the kidney and preventing post-traumatic sequelae, and (3) infected hematoma, which may develop in the observed case and which requires drainage. In the absence of critical hemorrhage, there is usually a period of 48 to 72 hours following injury during which diagnostic studies can be carried out. In this interval, infection and perinephric reaction are unlikely to develop, whereas bleeding tends to subside. Careful evaluation of the patient will result probably in the observation of more cases of closed injuries of the kidney.

Bladder Injuries

Traumatic rupture of the bladder results in extravasation of urine with subsequent necrosis and suppuration. Death will ensue without early diagnosis and proper treatment. The only satisfactory method of diagnosis is the cystogram, including an oblique film, made by using opaque contrast media. The objectives of treatment are suprapubic drainage of the bladder and thorough drainage of the perivesical tissues. The rent in the bladder is closed if this can be accomplished easily.

Surgical injuries of the urinary tract involve the bladder and the ureter, and may result from urological instrumentation, from abdominal and perineal surgery in both sexes, and from obstetrical procedures. Such injuries of the urinary tract, however, are most frequently associated with gynecological surgery. The actual incidence of urologic complications in gynecological surgery is unknown due to the reluctance of surgeons to report such cases but it is estimated to range from three per cent in ordinary pelvic surgery to as high as 10 per cent in radical surgery for malignant conditions.

During pelvic surgery in the female, the urinary bladder may be torn, incised, sutured, or have its blood supply compromised. Injuries of the bladder present little trouble if they are recognized at the time of surgery. The treatment is simple consisting of repair with absorbable suture material followed by constant urethral catheter drainage for at least 10 days. Injuries, which are not recognized, will result in urinary fistulas. Bladder wounds, which result in leakage of urine from the abdominal incision following supravaginal procedures, will usually heal if bladder drainage is maintained by indwelling urethral catheter. Vesico-vaginal fistulas, however, seldom close without surgical

*Presented at the May 19, 1956 meeting of the Kentucky Surgical Society at French Lick, Indiana.

intervention. Time does not permit a discussion of the many operative procedures designed to close vesico-vaginal fistulas, but regardless of the method of closure, two basic principles apply. First, no attempt should be made to close the fistula until all devitalized tissue has disappeared, and until the tissues are soft and pliable. This means waiting four to six months. Secondly, constant decompression of the bladder must be maintained for two to three weeks following surgery. The success of surgery for vesico-vaginal fistula will be enhanced by pre-operative cleanliness and eradication of local infection by means of urinary antiseptics and douches. Estrogens will improve the health and the regenerative powers of the vaginal mucosa.

Ureteral Injuries

The pelvic portion of the ureter in the female, because of its anatomical relations, is vulnerable to injury during gynecological surgery. The surgeon, therefore, should use every available means to prevent such complications. There is no certain method by which ureteral injuries can be avoided, but there are basic fundamentals which, if observed, will tend to decrease the incidence of such injuries. The surgeon should be familiar with the various possible anomalies of the ureter and also with the deviations of the ureter which might result from disease processes. Pre-operative studies of the urinary tract enable the surgeon to plan his attack with intelligence. In obviously difficult cases, it is helpful to introduce ureteral catheters prior to surgery, but this is not fool proof for many reasons. During surgery, the following principles apply: (1) identify all structures before clamping, cutting, ligating, or suturing, (2) avoid mass ligatures, (3) use absorbable suture material in or near the urinary tract, (4) place sutures carefully in the pelvic peritoneum, and (5) check the continuity and the course of the ureters before closing.

The ureter may be injured by ligation, crushing, incision, angulation by a suture, or penetration by suture. When the injury is recognized at the time of surgery, immediate repair should be undertaken for this is the optimum time for repair. Longitudinal tears or incisions can be treated like a uretero-lithotomy incision by adequate extra-peritoneal drainage. Transverse incision or sectioning is best treated by an end to end anastomosis over a ureteral catheter preferably or over a T-tube. Three or four sutures of number 0000 chromic cat gut are usually sufficient. Extra-peritoneal drainage is necessary to care for any leakage. If anastomosis is impossible, the proximal ureter should be reimplanted into the bladder. Most ureteral injuries complicating gynecological surgery are low enough to permit reimplantation without too much tension. Crushing of the ureter may cause necrosis of the crushed segment with subsequent extravasation of urine. For this reason, it is advisable to resect the crushed segment, and then treat as a transverse section. Ligatures and sutures, of course, should be removed if it is realized that they incorporate the ureter.

In all cases, conservation of the kidney is essential. Deliberate ligation of the injured ureter implies definite knowledge of the condition and the function of the opposite kidney. Such knowledge cannot be derived from mere palpation of the opposite kidney. If the continuity of the ureter can not be restored, ureterostomy or nephrostomy should be employed until the other kidney is proven to be capable of maintaining life.

Injuries of the ureters, not recognized at surgery, make themselves known in the post-operative period by anuria, oliguria, hematuria, pain, fever, and fistula formation. Any of these symptoms demand urologic investigation. Ureteral injuries detected following surgery present a much more complicated problem. Bilateral ligation of the ureters requires bilateral nephrostomies to preserve renal function until definitive treatment is possible. Deligation of the ureter in the post-operative period is too uncertain to depend upon in the face of bilateral involvement. After nephrostomy drainage has been established, it is advisable to await absorption of the ligature in the hope that the ureter will recanalize. This failing, reimplantation into the bladder should be attempted. With unilateral ligation, it is felt that deligation is permissible if the opposite kidney is normal. This is facilitated by introducing cystoscopically a ureteral catheter and then, by pushing up with the catheter, identify the point of ligation. After the ligature is removed, the catheter is advanced and left indwelling as a splint. Urinary extravasation will develop from laceration, incision, crushing, or suture penetration. Exploration of the ureter is warranted, for in the absence of transverse incision, splinting with ade-

quate extra-peritoneal drainage may suffice. The severed ureter is not amenable to anastomosis in the post-operative period because of the inflammatory reaction. Such injuries are best treated by reimplanting the proximal ureter into the bladder.

Uretero-enterostomy has not been mentioned because it is felt that this procedure with its complications is useful only when operations of choice are not adaptable. Of course, there are cases of unilateral injury in which nephrectomy will offer the most certain means of a cure. The method of treatment is influenced always by the age and condition of the patient, by the function and condition of the opposite kidney, and by the prognosis of the gynecological disease for which surgery was performed.

Case Reports

I would like now, with your permission, to present three cases which illustrate to some degree the management of delayed ureteral injuries.

Case 1. J. W., a white female aged 49, was admitted to Saint Joseph Infirmary on May 3, 1955, with the diagnosis of third degree retroversion of the uterus and varicosities of the broad ligament. A pan-hysterectomy was done with no difficulty. The post-operative course was uneventful and the patient was discharged on the eighth day following surgery. On May 20, 1955, the sixteenth post-operative day, the patient was readmitted with a small bowel obstruction in the region of the lower ileum. The abdomen was reopened, and there was found on the left side deep in the pelvis an abscess cavity which contained a large amount of milky fluid. A loop of ileum was densely adherent in this area, and was completely obstructed. It was necessary to resect the ileal loop and do an end-to-end open anastomosis. The pelvic abscess cavity was drained. Post-operatively, urinary leakage developed from the abdominal wound, and it was apparent that the pelvic abscess contained extravasated urine. Urological consultation was requested. Cystoscopy revealed the bladder to be intact but the left ureter could not be catheterized beyond six centimeters. Contrast media, which was injected into the distal left ureter, demonstrated a complete obstruction and medial displacement of the left ureter. By intravenous pyelography, the left kidney had impaired function and was hydronephrotic, while the left ureter was dilated down to its lower third from which the contrast media extravasated. The right kidney was normal. A diagnosis was made of ureteral fistula due to avascular necrosis secondary to either crushing or penetration by a suture. The later was favored because of the medial displacement of the left ureter. The left ureter was explored extraperitoneally. The ureter was pulled far medially and was completely obstructed by a severe angulation at which point in the urethral wall there was a fistulous opening. Severe inflammatory reaction was present in the lower ureter, and to reimplant it into the bladder would have required a very high sectioning in order to obtain healthy ureteral tissue. The ureter was freed down to the bladder and then through a small stab wound in a normal segment of the ureter, a splinting polyethylene ureteral catheter was threaded down to the bladder and up to the renal pelvis. Extra-peritoneal drainage was established. The bladder end of the splinting catheter was brought out the urethra by means of a cystoscopic forcep. Post-operatively, urinary leakage from the wound ceased in four days. The splinting catheter was removed in 10 days. Intravenous pyelograms made two months later revealed prompt function of the left kidney with no evidence of hydronephrosis. The left ureter was normal except for slight dilatation in the lower third, but there was no interference with drainage. This case illustrates the remarkable regenerative powers of the ureter with proper splinting in the absence of obstruction. The treatment employed might be considered a modification of the Davis intubation technique. It is not applicable to transverse injuries which will form obstructive strictures.

Case 2. M. M., a white female aged 30, was admitted to the Norton Memorial Infirmary on November 15, 1949, and a pan-hysterectomy was done for an intracervical submucous fibroid. Between the internal os and the external os, the cervix had been enlarged and elongated by a huge leiomyomata measuring 11 centimeters in diameter. Because of the pathology present, the surgery was difficult. Post-operatively, the patient developed hematuria, pain in the left renal area, and urinary leakage from the vagina. Urological consultation was requested. Cystoscopy revealed the bladder to be intact but it was severely traumatized with generalized mucosal hemorrhage and edema.

Both ureters were obstructed at four to five centimeters above the bladder, and catheters could not be passed beyond the obstructions. By intravenous pyelography, no function of the left kidney could be demonstrated and there was delayed function of the right kidney. Delayed pyelograms showed extravasation of the contrast media from the lower third of the right ureter. A diagnosis was made of ligation of the left ureter and incision of the right ureter. Immediate bilateral nephrostomies were advised to conserve renal function until definitive measures could be undertaken. It was felt that any attempt to deligate the left ureter was too uncertain in the face of an impaired opposite kidney, and reimplanting either ureter was precluded by the unhealthy state of the traumatized bladder. The patient refused the recommended treatment for a period of two weeks during which time she became septic and uremic. On the fourteenth day, she submitted to surgery but a left nephrostomy only was done because of her condition. Seven days later a right nephrostomy was done. Four weeks later, or six weeks following the initial surgery, the left ureter had recanalized and the left nephrostomy was discontinued with prompt healing. The ureterovaginal fistula, however persisted. The right ureter was exposed transperitoneally. The ureter was dilated down to the region of the uretero-vaginal fistula where it was densely adherent and could not be freed. The right ureter was sectioned and the proximal end was reimplanted into the bladder. The right nephrostomy tube was removed 12 days later. The last intravenous pyelograms were made of this patient five years following the reimplantation. These films demonstrate good function of both kidneys, and the kidneys and ureters are considered to be normal. The patient apparently has no reflux into the transplanted ureter. Recanalization of the ureter is probably rare but it is worth waiting for after the kidney has been protected by nephrostomy drainage. As in this case, the condition of the bladder must be considered before attempting to reimplant the ureter. This case is of added interest in that it provides clinical evidence to substantiate laboratory study that an uninfected kidney can be completely obstructed for two weeks without permanent loss of function.

Case 3. R. M., white female aged 52, was admitted to Saint Anthony Hospital on October 10, 1954, with the diagnosis of endometriosis of the left ovary. At previous surgery, the uterus, both tubes, and the right ovary had been removed. Left oophorectomy was done with no difficulty. Following surgery, the patient complained of pain in the left flank and an intravenous pyelogram was made on the fourth postoperative day. These films revealed no excretion of contrast media by the left kidney. The right kidney was normal. Urological consultation was requested and cystoscopy disclosed a complete obstruction of the left ureter at seven centimeters. Contrast media injected into the distal ureter retrograde confirmed the obstruction and revealed no evidence of extravasation. A diagnosis was made of ureteral obstruction due to a suture. Deligation was considered to be justified by the presence of a normal opposite kidney, and by the initial surgical procedure. For the attempt at deligation, the patient's lower extremities were spread apart and extended on long arm boards. This permitted preparation and draping of the perineum as well as the abdomen, and the foot of the table could be lowered so that cystoscopy could be performed during surgery without the inconvenience of the lithotomy position. The abdomen was opened and the dilated proximal left ureter was identified. The cystoscope was introduced, and a large ureteral catheter was passed to identify the level of obstruction. The ureter was found to be incorporated by two cotton sutures which were removed. The ureteral catheter was then advanced to the renal pelvis and left indwelling as a splint. The post-operative course was uneventful and the splinting catheter was removed on the seventh postoperative day. At present, the left kidney and the left ureter appear to be normal by intravenous pyelography. This case illustrates the advantages of close cooperation between the surgeon and the urologist, and offers a technique which at times is useful in attempting deligation of the ureter. The primary surgical lesion as well as the primary surgical procedure are factors to be considered before attempting deligation.

Summary

Brief comments have been made concerning the treatment of non-surgical wounds of the kidney and bladder. The incidence and types of

surgical injuries of the bladder and ureter have been mentioned. Basic principles, which tend to decrease surgical injuries of the urinary tract, have been outlined. The management of such injuries has been reviewed. Three cases of delayed ureteral injuries have been presented.

IMPLANTATION CARCINOMA IN THE INCISION ATTRIBUTABLE TO DESQUAMATED MALIGNANT CELLS*

D. P. Hall, M.D.**
Louisville

THIS SUBJECT is presented in the hope of stimulating discussion and eliciting the experience of others in one phase of cancer surgery which is believed to be deserving of more thought at the time of operation.

DePeyster and Gilchrist have set forth certain criteria for adequate surgery in carcinomatous lesions: (1) to prevent manipulative venous spread; (2) to prevent implantation; (3) to remove the malignant tumor by en bloc excision with the dependent echelons of lymph node spread.

During the past quarter century surgeons have concentrated on the development of more extensive surgical procedures in their attack on malignant lesions. That their efforts have borne fruit is attested by increased survival rates. Much attention has been directed to permeation of the cancer cell along lymphatic drainage pathways and little thought has been given to the implantation of viable cancer cells in the incision.

It is my opinion that many surgeons do not display sufficient awareness in the prevention of the implantation in the incision of viable carcinoma cells. Upon finding a malignancy of the breast at biopsy, many of us carry out a very thorough aseptic surgical ritual in the changing of gloves, drapes and instruments before proceeding to a radical mastectomy. One does not often see such meticulous care as the foregoing when a similar condition prevails in the course of an abdominal procedure, indeed it is not so rare to see malignant lesions extirpated without benefit of protective covering and many times the incision not protected down to the peritoneal edges.

Many of us came up under the waning shadow of the Mikulicz—Paul—Bloch exteriorization maneuver so universally used two decades ago in the resection of a malignancy bearing colon. This procedure resulted in a great number of implantation carcinomas in the incision. Certainly the poor results obtained coupled with the need for immediate decompression of the colon gave Rankin reason for devising the operation of immediate extraperitoneal resection of the growth bearing colon. When one considers general peritoneal metastasis and the frequency of implanted carcinoma cells on the serosa in the presence of active new growth, one must recognize the great fertility offered by the incision as a favorable soil for the implantation of viable cancer cells. Here one finds in the reparative process a closed and sheltered habitat for the viable cancer cell with heat, increased blood flow, capillary permeability, great amounts of lymph and a selection of tissues to act as host.

All of us are familiar with so called desquamated "dropped cancer cells" found in the pelvis in many intraabdominal malignancies. It is probable that only a few of these are viable, yet they offer a great source of implantation into the incision. On several occasions we have introduced saline solution into a dry pelvis and recovered the solution by means of a syringe. Upon centrifuging the solution and examining the sediment with the aid of Papanicolaou stain many carcinomatous cells have been found.

We have been impressed of late by the appearance of carcinomatous nodules in the incisions of patients who have undergone surgery for an intraabdominal lesion. In these operations, the lesion had not been completely isolated by protective covering nor had the draping of the incision by impervious material extended to the peritoneum, in order to adequately exclude the incision. Presumably there was not a change of gloves or instruments on closing the incision.

In considering these experiences it was decided to follow the guidance and advice of the Apostle Paul, "to prove all things and hold fast that which is good." In malignancies of the

**From the Department of Surgery of the University of Louisville School of Medicine and the University of Louisville Hospitals.
*Presented during the annual meeting of The Kentucky Surgical Society, May 19, 1956, French Lick, Indiana.

colon smears were made by contact of a glass slide and by gentle edge scraping of the serosa over the lesion. These were examined by the Papanicolaou method and in approximately 15 per cent of smears carcinoma cells could be demonstrated. In several examinations of the serosa in lesions classified as Duke's A, cancer cells were found. This would seem a potent reason for isolating, if possible, the tumor bearing area and the incision with an impervious material.

Illustrative Histories

The following abbreviated histories may be illustrative: Mrs. A. R. aged 74 was hospitalized in December 1949 because of recurrent attacks of gall stone colic, extending over a period of eight years. The attack on admission covered two days and required morphine on several occasions for relief of pain. A scout x-ray film of the abdomen revealed many stones in the gall bladder. At operation a thick walled gall bladder containing numerous stones, one of which was impacted in the cystic duct was found. A cholecystectomy was done followed by an uneventful recovery. The tissue examined was reported as chronic cholecystitis with stones (Fig. 1.).

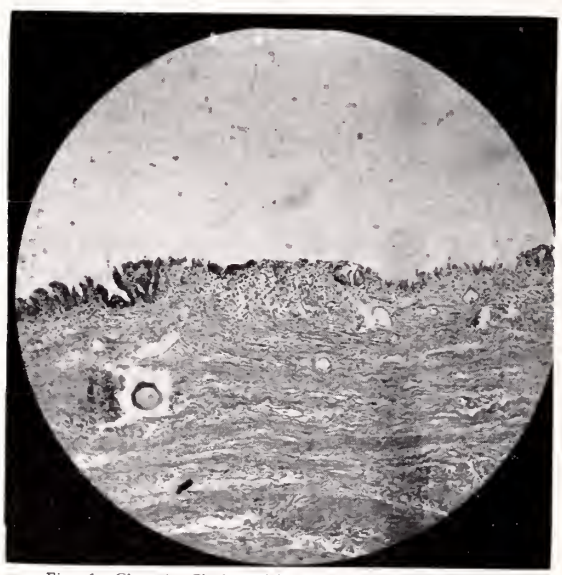


Fig. 1. Chronic Cholecystitis with Carcinoma in Situ.

The patient returned to the hospital on September 12, 1951, one year after her previous operation with a hard fixed nodule in the lower one third of the old healed incision. A wide excision of the old scar with the nodule, including all layers of the abdominal wall was done.

A second look into the peritoneal cavity revealed no gross metastasis. The tissue examined was reported as carcinoma of the abdominal wall consistent with gall bladder origin (Fig. 2.). The sections cut after the first operation were re-examined and a carcinoma found which had been overlooked at the first tissue examination.

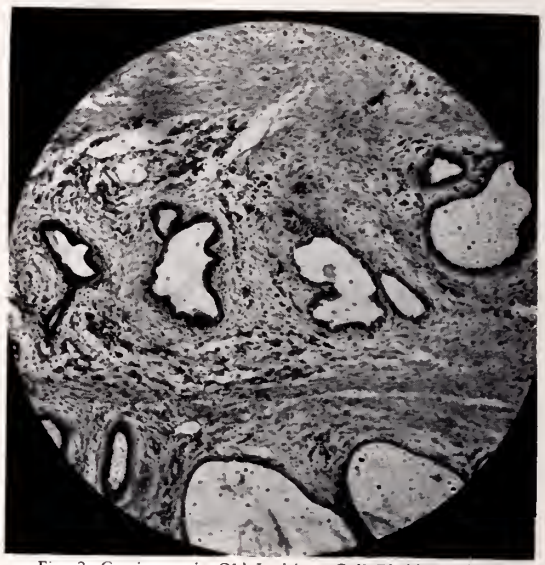


Fig. 2. Carcinoma in Old Incision, Gall Bladder Origin.

The incision at the primary operation upon this patient was not protected down to the peritoneum. It may be of interest to know that this patient is now living seven years since her cholecystectomy. She is the only patient with primary carcinoma of the gall bladder we have had to survive over 12 months.

Mr. D. D. aged 71, was hospitalized in March 1955 because of weakness and melena. He presented no obstructive symptoms. A barium enema with x-ray of the colon revealed a carcinoma of the ascending colon 10 c.m. above the cecum. At operation a right hemicolectomy was done, including the terminal

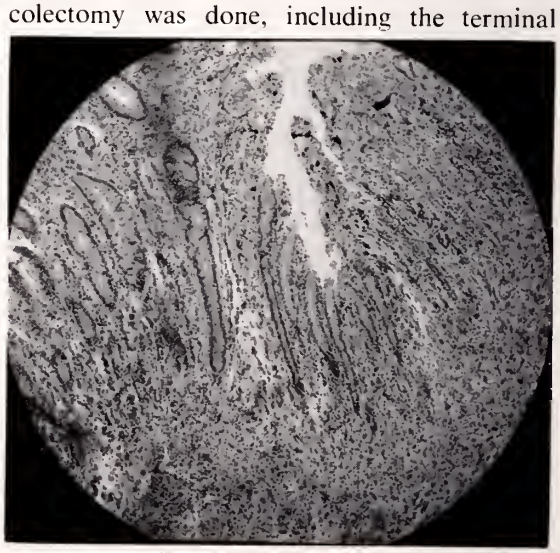


Fig. 3. Carcinoma of the Colon

ileum and right half of transverse colon with an end to end anastomosis. The tissue examination was reported as adenocarcinoma of the colon (Fig. 3.).

One month after his operation a hard fixed nodule was found in the midportion of his old incision. The old scar was excised with the nodule en bloc. The tissue examination was reported as carcinoma of the abdominal wall (Fig. 4.). No protective covering was used around the growth at the primary operation and there was no protection of the incision down to the peritoneum.

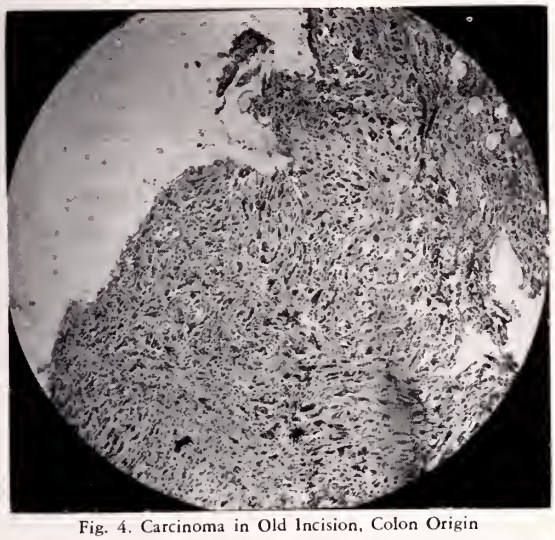


Fig. 4. Carcinoma in Old Incision, Colon Origin

S. H. aged 74 was hospitalized in January 1955, because of hematemesis. Indigestion had been persistent for a two year period. He had lost no weight but had been unable to gain. An upper gastrointestinal x-ray revealed an ulcer crater in the prepyloric area of the stomach which was non-obstructive and questionable as to malignancy. An extended subtotal gastric resection was done. The tissue examination was reported as a prepyloric carcinoma of the stomach.

Nine months following his resection a hard, firm, fixed nodule was found in the midportion of the incision. The old scar was excised including a wide area surrounding the nodule with all layers of the abdominal wall. A second look revealed no gross recurrent lesions intraperitoneally. This tissue examination was reported as carcinoma of the abdominal wall (Fig. 5). No protective covering was used down to the peritoneum at primary operation.

These three histories present but a few incisional implantations but they are sufficiently representative in general surgery to increase

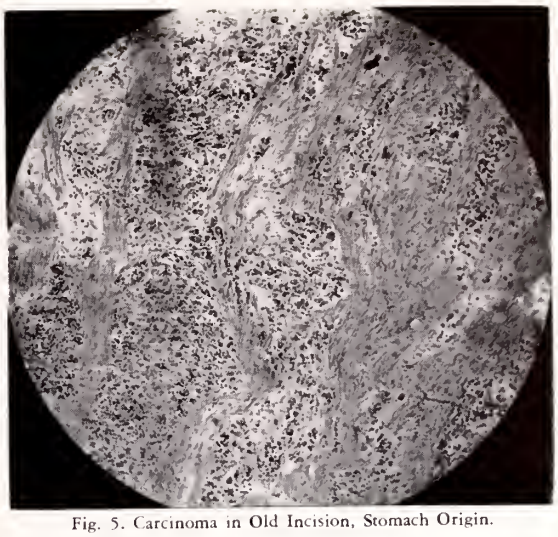


Fig. 5. Carcinoma in Old Incision, Stomach Origin.

our awareness as to the implications of one of the criteria, as set down by DePeyster and Gilchrist, namely, prevention of implantation carcinoma.

It would seem that a lower rate of implantation carcinoma in the incision might be obtained by following three procedures, which are well known but not used routinely, as wisdom might dictate.

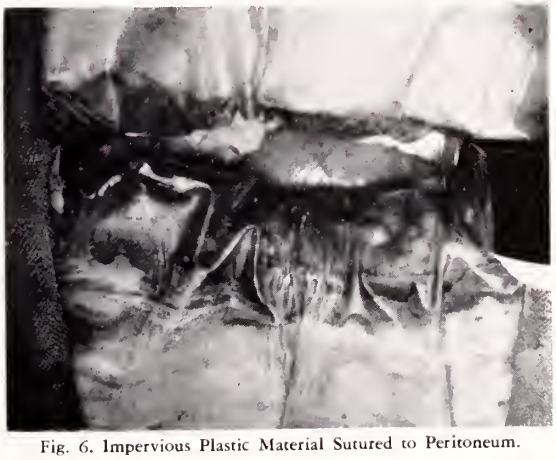


Fig. 6. Impervious Plastic Material Sutured to Peritoneum.

One, the suturing of impervious material to each leaf of the incised peritoneum thus protecting the incision (Fig. 6).

Two, isolating the malignant area at the earliest stage of the operation, by gauze affixed to the area by ties or clamps.

Three, before closing the incision a change of gloves by the operating team with the use of fresh drapes and instruments.

In conclusion, an aphorism of Da Costa may be apropos "The complete radical is wrong. The complete conservative is wrong. Surgical fashions change as rapidly as fashions in battleships or woman's headgear."

CHANGING CONCEPTS IN THE MANAGEMENT OF ECLAMPSIA WITH SPECIAL EMPHASIS ON HYPOTENSIVE DRUG THERAPY*

GEORGE G. GREENE, M.D.
Lexington

THERE is little known about the history of eclampsia. Apparently, the disease was known to the Greek physicians, as it was from Hippocrates that we received the name "eclampsia." This Greek word was used to describe a condition of sudden onset of fever, although the "father of medicine" may have had in mind any one of many conditions accompanied by sudden onset of fever.[1] Eclampsia is still a serious complication of pregnancy. Statistics still place this condition as a "killer" to the pregnant woman and her unborn infant. It is responsible for 30 per cent of all maternal mortality, at the same time taking a death toll of 30,000 infants each year in the U. S. A., either in stillbirths or neonatally.[2]

Etiology

The etiology is not definitely known, and only a few sentences would be necessary to cover this subject completely. However, thousands of pages have been written on various and sundry theories. Eclampsia has been called the "disease of theories." I do not propose to labor on this subject and the details of theory. However, I do wish to discuss some of the more commonly known and generally preferred thinking along this line. Finally, I will momentarily digress on a theory which you might call "fantasy," but which I feel is reasonable and sound.

The theory most widely accepted today was advanced in 1914 by John Young, M.D., and has subsequently been sponsored by many other eminent authorities.[3] This is the theory of uterine ischemia. This postulates that the large blood supply which the uterus in pregnancy normally receives may become impaired by a number of factors: (1) Mechanical conditions in or about the uterus hindering adequate blood supply. (2) Nervous factors which influence blood flow through the autonomic nervous system. (3) Deficient adaptation of the general circulation to the requirements of the pregnant uterus and labor.

Examples of mechanical conditions are multiple pregnancy, hydatidifirm mole, and proximity to term.

The role of the autonomic nervous system in vasomotor functions is well known; the part it plays in hypertension, if any, is not known. The work of Assali with Tetraethyamoniumchloride tends to favor the humoral effect more than the neurogenic.[4]

Inefficient adaptation of the general circulation to the requirements usual in pregnancy might come from a number of sources. This might be expected particularly in diseases like hypertensive cardiovascular disease, in which there is general sclerosis of the arterioles, thereby hindering an adequate blood supply to the uterus. This fact is borne out by the presence of pre-eclampsia in about one-fourth of all chronic hypertensive vascular disease patients. Another disease is that of long-standing diabetes, in which there is calcification of the walls of the uterine arteries. We are well aware of the fact that diabetics are prone to develop pre-eclampsia and eclampsia.

In reviewing the etiology of eclampsia, I found a copy of Dr. John King's textbook on "Electic Obstetrics," which was written in 1896.[5] I wish to quote verbatim some of the causes of eclampsia found in this work:

> "Puerperal convulsions are not well understood. They appear to be multiform. Plethora, compression of the aorta, long-continued mental excitement, highly electrical conditions of the atmosphere, weather which is persistently damp and foggy, and profuse hemorrhages in previous conditions or in injuries to the head have been variously named as predisposing causes. Females, not married, who do not enjoy the pleasures of society and are particularly given to the use of liquors, are especially liable to them. It has been supposed that blood poisoning from the retention of urea, occurring either from the presence of Bright's Disease or from the pressure upon the emulgent veins by temporary congestion upon the kidney, has occasioned the paroxysms."

This author goes on at great length and discusses many and sundry things that might be factors in initiating eclampsia. He warns his

*Read before the Daviess County Medical Society and Second Councilors District Meeting at Owensboro, Kentucky, April 1956.

students to be particularly careful with those females having short necks; those having firm, solid, and unyielding tissues; those who possess great muscular strength; and those whose hands and feet swell, who experience a numbness in their hands or in the limbs, with swelling of the face on awakening every morning. He does not forget to caution especially the physician who knows "for several weeks previous to the delivery that he is going to be in attendance at the labor" to determine whether albumin be present and urea diminished in amount.

Another theory which I wish to mention is partly my own. It is that of anaphylactoid reaction due to absorption of fetal products from the maternal blood stream.[6] Many years ago, Tarnier and his students did some experimental work with the urine and serum of pregnant and eclamptic patients. The urine of eclamptic patients was injected into animals for evidence of toxicity, as was the urine of normal pregnant women. The eclamptic urine was not nearly so toxic to the animals as that of the normal pregnant woman. However, the serum of the eclamptic patient was much more toxic to the animals that received the urine from this experiment. This, of course, lends very definite proof that there is a toxic product circulating in the serum of the eclamptic patient, which is not being eliminated through the urinary system. This leads one to wonder what this toxin might be and where it originates. I feel that by combining the thinking on several theories we come to a very satisfactory explanation regarding the etiology of toxemia. First, if we use the theory of uterine ischemia in part, we readily understand that by hindering the blood supply to the placenta some damage would be done immediately. This, I believe, is the case, and certain fetal products are lost into the blood stream as a result of damage to them, such as the chorionic villi or the syncytial cells. When these have once entered the maternal blood stream, I theorize that they act as toxins to the vascular system of the pregnant woman and elicit an anaphylactoid type of reaction that causes arteriolar constriction. This would give us all the classical signs and symptoms that we find in eclampsia, such as hypertension, diminished urinary secretion, loss of albumin and edema. I believe that this toxin produces a marked, generalized vasospasm and that this is the originator of the convulsive attack we see in the eclamptic patient.

Someone will immediately ask why the variation in eclamptic patients in one section of the country as compared to that of the other. Such an outstanding teacher as Dr. Eastman, of Baltimore, in a recent article of his concerning the explanation as to why in 1930 his staff was seeing two or three cases of eclampsia every month in their clinic and is now seeing only one or two mild cases each year. He cites Kingston, capitol of Jamaica, as another good example, where the population is about one-seventh that of the population of Baltimore and still they will have approximately 65 eclamptic patients to every one in Baltimore. Of course everyone knows that good prenatal care has been the answer to eclampsia in this country. This is generally true everywhere. When this is considered, then immediately we have to find some other answer for the uterine ischemia as to etiology and put something else with it in order to answer the question that Dr. Eastman asks.

I would first try to answer this by saying that in my opinion as long as we supply patients with proper diet, including minerals and vitamins, the vascular tree is less likely to be susceptible to weaknesses and endotoxins which might be floating in the maternal blood stream. To me, this is much the same as fertilizing the ground where a shrub or flower has been planted and feeding and caring for it during its growth phase. On the contrary, if we do not, one readily knows the inevitable.

Prenatal Care

We have proved beyond all doubt that proper diet, freedom from worry, and other factors will definitely lower the incidence of eclampsia. In the early part of the century, the incidence of eclampsia was one per cent in many of the medical centers of this country. Even 15 years ago, it was much more prevalent in our own part of the country. Now we are seldom called upon to attend a case of eclampsia in pregnancy. This great stride forward was brought about largely by good prenatal care. To this, everyone agrees.

It is important that each one of us spend considerable time with our patients in the first part of their prenatal care particularly and explain to them the importance of a high protein diet, adequate vitamin and calcium intake, and the necessity for a low calorie regime. If we have a patient with an unusual amount of anxiety regarding her preg-

nancy, we should endeavor to find the cause, since this can certainly play an important role in the preventive treatment of toxemia. Emotional problems, certainly can aggravate or add to the insult already smoldering. I can, and am sure that each of you can immediately think of such instances in your own private cases.

According to Stare and Davidson, the actual protein requirements during pregnancy cannot be definitely stated, but 10 to 12 grams of additional protein per day has been suggested as the increased requirement. Arnell found that protein deficits were increased during pregnancy by the restriction of meat, eggs, and milk, either self-adopted or carried out on medical advice. Williams states that the incidence of toxemia in pregnancy was twice as great in one group of women whose protein intake was 60 to 70 grams daily as in a similar group whose protein intake ranged from 110 to 120 grams. Dieckman has stressed the importance of anemia and that it predisposes to edema. He states that albumin and globulin molecules are so large that they do not pass through the capillary walls. If this is true, they would exert colloid osmotic pressure within the capillaries. Therefore, a high protein diet should tend to prevent edema.

Luikart[7] states that in all cases of toxemia that he has examined the toxemia occurred in about four per cent of the patients who gained over 18 pounds. In 1000 women who had followed a strict weight control program throughout pregnancy, there was not a single maternal mortality or instance of toxemia. The fetal mortality was one-sixth of that in an uncontrolled group. The average birth weight was slightly less than 7 pounds.

A Classification of Eclampsia

I classify my toxic patients in groups as follows:[8] Grade one—only slight elevation of blood pressure and a small amount of albumin in the urine. Grade two—patients with marked elevation of blood pressure, albuminuria, marked edema, no convulsions. Grade three—same as grade two but convulsions present. Grade four—patients who have had previous kidney damage or are known hypertensives already, with convulsions superimposed plus other signs of toxemia.

Treatment

I should like to give you some of the pharmacology of veratrum viride, the drug on which I largely depend in the treatment of this disease.

Veratrum Viride is an alkaloid derived from the roots and rhizomes of hellebore. This plant is indigenous in both Europe and North America. The drug acts as a cardio-inhibitor, vasodilator, and antipyretic. It is toxic in large doses and must be given carefully. Toxic reactions include a sudden drop in blood pressure and pulse rate, nausea and vomiting, and eventually, coma. Toxic reactions may be counteracted by gastric lavage or atropine in the usual dose. The preparation I use is Veratrone® in doses of three to 10 minims, given by hypodermic injection.

I first became interested in the management of eclamptics with Veratrum Viride about 16 years ago. This interest was aroused by a report from an interne in a local hospital relative to the treatment used at the University of Cincinnati School of Medicine. As each of you know, this drug has become more widely accepted in the past few years and now stands with the members of its family at the top of the armamentarium for the treatment of eclampsia.

Veratrum Viride and its hypotensive relatives have become very widely used throughout the country in the past few years in the management of toxic cases, whereas only such centers as the University of Cincinnati and the University of Tennessee were using the drug more widely in the early '40's. There were, of course, a few isolated areas that had been favorably impressed with this drug. Most of the textbooks written in the first part of the twentieth century would give Veratrum Viride only a very small role in the treatment of eclampsia. Many authors would mention this drug but hastily pass on to other forms of treatment. However, some of the older authors as far back as 1890 or before were very much impressed with this drug, as was noted in reviewing Dr. John King's textbook, to which I have referred earlier in this paper.

I was much interested in the report that appeared in the October 1940 issue of the Journal of the American Medical Association, written by[9] Doctors Fleming and Bryant, who were associated with the University of Cincinnati. There, Veratrum Viride had been their main source of effective treatment for at least 15 to 20 years prior to the writing of this article. At that time they reported on approx-

imately 120 cases which had been treated. At that time they had lost only two patients, both of these having occurred a considerable time after the initial phase of the eclampsia.

During 1942, at the University of Tennessee, in Memphis, we had approximately 20 cases of what I term "true eclampsia," which were treated with Veratrum Viride. Not one of these patients died.

I then reviewed the institution's records of eclamptic patients for the six years preceding 1942.

In one year, 1937, there had been a great increase in Caesarean sections for the eclamptic patient, this being used as a part of the treatment, not requiring separate indication. Many of these patients were operated on before they had been in the hospital for as long as one to two days, having not been controlled or at least stabilized for the time being. Nearly all of these patients died. During the other years, there was almost every form of treatment used that has ever been mentioned in medical literature as far as I know. None of the statistics were in any way comparable to the 1942 statistics.

I have continued to use veratrum viride in the treatment of eclampsia. I have rarely used magnesium sulfate injections in the past 10 years. I believe that my results without the magnesium sulfate are just as good as when we used it. I have tried to stay away from all heavy sedation or analgesics except in cases in which active labor was present and warranted such.

I have recently communicated with the Department of Obstetrics of the University of Cincinnati, to learn if there had been much variation in recent years in the management of their eclamptic patients.[10] I cannot see that it has changed a great deal, although there are some minor changes. I was interested in the fact that they have not given up Veratrum Viride for any of the other hypotensive drugs. The treatment as described by them is not a great deal different from that I use. Their's is somewhat more extensive than mine, and they are still using the magnesium sulfate, as has been their custom for many years.

I am still convinced after a period of 14 years that Veratrum Viride is the most rational drug in the management of eclampsia, along with adjunctive measures. It, along with its various relatives in the hypotensive drug group, offers a therapeutic approach. Drugs such as the opiates, barbiturates, and magnesium sulfate, are central nerve system depressants and nothing more. I am not as familiar with apresoline and other related hypotensive drugs, but feel sure they may work equally as well as Veratrum Viride.

Conclusions

Although eclampsia is considered the disease of theories, I am not certain that the etiology is not known. I question this, and I feel that possibly we already know the etiology although we do not have a definite name to attach to the toxin that is liberated as a result of interference with blood supply to the pregnant uterus, as mentioned above. This toxin, I feel, is a result of a foreign protein of fetal origin being liberated into the maternal blood stream, which acts as an allergic factor and produces a generalized vasospasm of the arterioles, which in turn produce the signs and symptoms that we see throughout the body and in the urinary tract and blood stream as well.

We have proved to ourselves that we can largely eliminate eclampsia by good prenatal care; having our patients take increased quantities of proteins, adequate vitamins and calcium, and keeping the caloric intake low at the same time. The second important consideration is that of freedom from worry and undue anxiety. It is quite possible that the increased nervous tension in pregnancy has something to do with the initial vasospasm that helps to initiate the eclamptic condition. I personally feel that I have definite examples I can cite where this has been the case.

It would appear that we have eclampsia quite well under control, although not completely. I do not believe that we will ever be able to eradicate this problem in pregnancy, nor do I believe that we will ever find a serum or vaccine which will be preventive.

References

1. Stander's, H. J.: Williams Textbook of Obstetrics, Seventh Edition, 1936.
2. Chapman, E. R., Strozier, W. E., and Magee, R. A.: Am. J. Obst. & Gynec. 68:1109 (Oct.) 1954.
3. Eastman, N. J.: Obst. & Gynec. Survey, Editorial Comments from (Oct.) 1955.
4. Assali, N. S.: Obst. & Gynec. Surv. 9:776 (Dec.) 1954.
5. Kings, John: Textbook "Elective Obstetrics," Tenth Edition, 1896.
6. Greene, G. G.: Ky. Medical J. (March) 1948.
7. Linkart, Ralph: J. of Obst. & Gynec. Vol. 52, (Sept.) 1946.
8. Greene, G. G.: Am. J. Obst. & Gynec. (Oct.) 1944.
9. Bryant and Flemming: J. of Am. Med. Assoc. (Oct. 19) 1940.
10. Department of Obst. & Gynec.: Personal Communication, 1956.

MODERN CONCEPTS IN THE TREATMENT OF GOITRE*

W. Carl Kappes, M.D., F.A.C.S
Huntington, W. Va.

FOR PURPOSES of discussion of the diagnosis and treatment of goitre we use the classification of the American Goitre Association, viz:

A. Diffuse: (1) Toxic
  (a) Graves' disease
  (b) Primary hyperthyroidism
  (c) Hyperplastic
 (2) Nontoxic
  (a) Adolescent
  (b) Colloid

B. Nodular: (1) Toxic
 (2) Nontoxic

C. Malignancies:
 (1) Papillary carcinoma
 (2) Follicular carcinoma
 (3) Alveolar carcinoma
 (4) Hurthle cell carcinoma
 (5) Lymphosarcoma

Diffuse Toxic Goitre

This type has been variously labeled as Graves' disease, hyperplastic goitre and primary hyperthyroidism. The symptoms and signs are those of hypermetabolism such as nervousness, excitability, tremors, palpitation, marked weight loss despite ravenous appetite, quadriceps weakness and, in severe cases, nausea, vomiting and diarrhea. In most cases there is a low grade fever ranging from 99° to 100°. Examination reveals a wide pulse pressure and increased heart and pulse rates. The gland itself is usually fairly soft and, in most cases, there are bruits over the superior pole vessels. Not all cases of diffuse goitre have exophthalmos but this is always present in the typical Graves' syndrome. Regarding the latter, it has been shown by Dobyns[1] and others that there is an exophthalmotropic hormone which is separate from the thyrotropic hormone. It is in these cases that the thyroidologist has his headaches because, regardless of how the gland is obliterated, be it surgery or I^{131}, the exophthalmos may even progress.

The BMR is a test which merely gives the rate of oxygen consumption for a given length of time under certain conditions. We reason that when the rate is high the patient is toxic in direct proportion. If the test is run properly the rate usually fits in with the rest of the clinical picture. However, if the patient is unduly nervous, apprehensive and the "hose in mouth, nose clamped off" method is used, higher rates than expected may result. The point we are trying to make is that the BMR is an adjunct in the diagnosis and not the diagnosis per se. A good clinical diagnosis is far more important than the BMR.

Increased PBI

In hyperthyroidism the protein-bound iodine content of the blood is elevated over 14 mcgms per cent and, when facilities are available for an accurate test, we have another diagnostic measure in hyperthyroidism. When accurately done, the increased uptake of I^{131} is also a valuable adjunct in the diagnosis of diffuse toxic goitre. The blood cholesterol usually runs below 150 mgm per cent in hyperthyroidism and this can be used to complete the picture. These laboratory tests, while important, cannot and will not take the place, however, of a good clinical examination and evaluation of the patient.

Treatment Iodine

Since the introduction of Lugol's solution by Plummer in 1922 in the treatment of hyperthyroidism, the mortality rate following surgery has been reduced to a minimum. In the average case of uncomplicated toxic goitre in which the symptoms have been present less than 12-18 months, the cardiac status is good, and if the patient has not had prolonged iodine or antithyroid medication previously, the patient can be prepared for surgery on iodine alone. As a rule Lugol's solution is given in doses of thirty drops daily for two to three weeks, or until the gland becomes firm, the pulse rate slows and weight increases, and other signs of improvement appear.

*Read before Johnson County Medical Society, Paintsville, Kentucky, April 19, 1956.

Antithyroid Drugs

In 1943 Astwood introduced the use of antithyroid drugs. The various ones now in use such as Thiouracil, Propyl-thiouracil, Tapazole, and Itrumil, have proven valuable adjuncts in the treatment of toxic goitre. When Lugol's solution was introduced it was thought at first that surgery would not have to be done. The same was true after the introduction of the antithyroid drugs, but time has shown that these drugs are usually only adjuncts in preparing patients for surgery. We can, however, usually carry children for quite a long time on a medical regime and, in many of these cases, surgery will not be required. In the severely toxic cases, in the thyrocardiacs, and in those who have become iodine fast or iodine resistant, the use of antithyroid drugs is paramount in preparing patients for surgery. Personally, we prefer Propylthiouracil. The dosage can vary from 300 mgm to 1000 mgm daily, depending on the severity of the disease. We check the leucocyte count every two or three weeks but the incidence of granulocytopenia or agranulocytosis is extremely low. When the antithyroid drugs have been given to the point where the BMR is slightly above normal and there are favorable clinical signs of improvement in the patient, the drug is discontinued and Lugol's solution in doses of ten drops thrice daily is given for approximately three weeks or until the gland has become firm. This is important because we have learned from sad experience that if the gland is not well involuted we have a soft, very friable gland which makes the operation a very bloody and hazardous one.

Radioactive Iodine

When I^{131} was first introduced in 1942, the advocates of its use were very enthusiastic but, as time has gone on, it has been shown that it is not a cure-all. It seems to be the consensus in most clinics that there are three main indications for its use: (1) Recurrences. When a thorough thyroidectomy has been performed and there is a recurrence, it may become hazardous to repeat surgery because of the danger of injuring the parathyroids and the recurrent laryngeal nerve. It seems safer in these cases to use I^{131}. (2) Thyro-cardiacs. In cases in which the cardiac reserve is extremely low and surgery is hazardous, we are justified in giving I^{131}. Even though the gland is not completely obliterated, a sufficient amount can be destroyed so that the patient can be rehabilitated to the point that surgery can be done at a later date. (3) If necessary, in some patients over 45 years of age who refuse surgery for one reason or another, I^{131} can be used with safety. Since we are not sure about the carcinogenic effect of I^{131} on humans because sufficient time has not elapsed to prove this, and since we are not sure about its effect on the reproductive system, one should be conservative in the use of I^{131} in the young patients.

Borderline Cases

From time to time we are confronted with a patient in whom we cannot make a definite diagnosis of hyperthyroidism. We can run a BMR, a PBI and a radioactive uptake study and still not be absolutely sure. In these cases we take the attitude of "scientific neglect" which consists of watching, waiting, giving a little iodide, a little phenobarbital, and a lot of reassurance. If left alone for a sufficient length of time they will either get well or develop a true hyperthyroidism. If this attitude is not taken, poor results can be expected with surgery. There is nothing more discouraging than to operate and have the patient complain as much, or more so, than before operation.

Nodular Goitre

The treatment of toxic nodular goitre is about the same as in the diffuse type. Although I^{131} is not recommended in the treatment of nodular toxic goitre, as a rule, sometimes it is necessary to treat them somewhat less adequately with I^{131} because the cardiac status will not permit surgery to be done until the toxic symptoms have been alleviated. When the cardiac status is corrected, the removal of the nodule is safer. It is becoming more apparent to all that the treatment for so-called nontoxic nodular goitre is surgery immediately. We cannot understand how some physicians can be so complacent in advising patients with a nodule in the thyroid to "leave it alone until it bothers you." I'm sure that these physicians would advise immediate investigation of a lump in the breast. A solitary nodule of the thyroid, particularly in children and males, is just as prone to malignancy, from 17.7 per

cent (Cole) to 24 per cent (Rawson) of cases, as a breast tumor. Cole[2], et al, recently reported that the incidence of carcinoma in nontoxic nodules in childhood was 39 per cent. It is of further interest that out of every 12 children under 15 years of age who had carcinoma and were included in this report, 10 (83 per cent) had been given x-ray therapy to the neck or chest in early childhood. We advise all of our cases of nodular goitre to submit to surgery because we know that (1) they will sooner or later develop cardiac irregularities, and (2) the incidence of malignancy is too high to allow procrastination.

Malignancies of the thyroid are varied, but the papillary adenocarcinomas are the most amenable to treatment since the metastases have a tendency to remain localized. The follicular types and the lymphosarcomas offer the least favorable prognosis. It was hoped at one time that I^{131} would be the panacea for the treatment of malignancies of the thyroid with their metastases but it has been found later that only in those cases where there is a good uptake (thirsty gland) is there much to offer these patients. It has been found that large doses (three or four grains daily) of thyroid extract postoperatively will aid in holding the disease in check.

The decision as to whether to do a radical neck dissection in malignancy of the thyroid is a very difficult one to make at times. If there is a lymph vessel invasion only, one seems justified in doing a radical dissection but, if there is already blood vessel invasion as shown on microscopic section, then radical surgery seems to be of little avail.

Thyroiditis

Acute suppurative thyroiditis is rare and can be controlled with antibiotics, but occasionally incision and drainage is necessary. The so-called subacute granulomatous thyroiditis is fairly common and is frequently overlooked or mistakenly diagnosed. The symptoms and signs are fairly clear-cut; viz., pain over the gland radiating to one or both ears, marked tenderness, symptoms resembling a virus infection such as fever, chilliness, etc. Although small doses of x-ray over the gland will relieve the patient, we have in the past few years given Thiouracil in 0.2 gm doses three times daily for not over four days. This treatment, though unexplainable, was suggested to us by Brian King, M.D.[3] It is spectacular to note the effect of this drug in relieving the symptoms of pain, fever and general malaise. For some unknown reason Propyl-thiouracil and other antithyroid drugs do not work. Of course one should check the leucocyte count and be on the alert for symptoms of agranulocytosis. Some clinicians have used Cortisone for subacute thyroiditis but we have not had any experience with it.

Chronic Thyroiditis

The two main types of this disease are Hashimoto's struma and Riedel's struma. When one encounters either of these conditions it is difficult at times to differentiate them from malignancy. Some clinicians favor needle biopsy but this is not always satisfactory. Lahey has brought out a point worthy of mention in differentiating these two types of thyroiditis from malignancy; viz., in either of these conditions the general contour of the gland is maintained if careful examination is made, whereas in malignancy (advanced) the contour of the gland is lost. As to treatment, surgery seems the treatment of choice and one need not fear doing too radical a resection because those cases require fairly large doses of thyroid extract for a lifetime, otherwise myxedema will result.

Operation

The technique of thyroidectomy seems fairly well standardized now, but there are a few points relative to technique to be emphasized: (1) careful separation of the superior pole vessels from the ala of the thyroid cartilage before ligation is very helpful in avoiding injury to the recurrent laryngeal nerve in this location, (2) we have found that if we begin the dissection from the isthmus and proceed laterally we have a better control of the operation so far as bleeding is concerned, (3) although we do not routinely transect the prethyroid muscles, if we are in doubt as to good exposure we do not hesitate to do so and find that a better anatomical dissection can be made, and (4) a careful search should be made for the parathyroids so as to avoid removing them or injuring them.

Postoperative Complications

(1) Nerve injuries. We do not routinely dissect out the recurrent nerves although we are

ever mindful of their position. We do not believe it to be essential and is safe only in the hands of the experienced operator. Too much trauma to these nerves can cause temporary paresis with resultant obstruction to the airway. The most frequent point of injury seems to be the superior pole and for this reason it is very important that one dissect out the superior pole vessels carefully before ligating them. (2) Hypoparathyroid tetany. Regardless of how careful one may be in preserving the parathyroids, tetany results in two or three per cent of cases. When tetany appears we get a blood calcium determination and then give 10cc of 10 per cent calcium gluconate intravenously. We immediately start the patient on Di-cal D capsules or wafers every four hours and gradually reduce the dose. Most of these cases are transient unless two or more parathyroid bodies have been removed. We have had at least two cases that have cleared up as long as 18 months after operation. Rigdon[4] recently reported a case of severe chronic tetany which did not respond except to huge doses of calcium in which he transplanted to the rectus muscle the parathyroids removed from a four months' old fetus with a dramatic result. Sterling[5] has reported a case in which he removed the thyroid gland together with the parathyroids and anastomed the vessels to the superficial femoral vessels. (3) Tracheotomy. (a) Emergency. Regardless of the care used in doing a thyroidectomy, one is sometimes confronted with the necessity of doing an emergency tracheotomy. The nerve supply after operation may be intact but edema can be of such severity that an immediate operation is necessary. One has a tendency to put off this operation, hoping that the patient will improve. Delay is usually fatal. Lahey has said "the time to do a tracheotomy is when you are wondering whether or not you should." (b) Elective tracheotomy. To our mind there are two indications for elective tracheotomy at the time of operation. First, in very large goitres of long standing where we expect and usually do get marked edema with resulting stridor and anoxia, it is very good procedure to circumvent this by doing the operation. The tube can be removed in three or four days and the scar is not bad. In fact, in a number of cases I have hoped the patient would live to get a bad scar. Secondly, at the suggestion of Dr. Bartels, the surgeons of the Lahey Clinic do elective tracheotomies on the severe thyrocardiacs where the cardiac reserve is low and where the slightest amount of anoxia following surgery may be the deciding factor. Oxygen can be administered continuously through the tracheotomy tube. (4) Persistent or progressive exophalmos. Fairly conclusive proof has been presented by Dobyns that there is an exophthalmotropic hormone of the anterior pituitary which accounts for the exophthalmos of Graves' disease and, whereas we do not as yet know how to cure the condition, we do have at least two ways of helping the patients. First, adequate continuous doses of thyroid extract following thyroidectomy will frequently hold the condition in check. Secondly, the Naffziger decompression operation or some modification thereof, will help in a large number of cases. Recently Moran[6] has shown that, despite adequate orbital decompression, the exophthalmos progresses and he also noted that these cases had marked levator spasm. By removing most of the fibers of the levator muscles, the exophthalmos improved markedly so that in cases of marked levator spasm, he does the simpler procedure first and, if necessary, the decompression operation later. (5) Hyperthyroidism in pregnancy. The consensus seems to be that surgery is the treatment of choice during the first two trimesters of pregnancy and the use of antithyroid drugs and iodine in the last trimester. It also seems that I^{131} should not be used during pregnancy.

Post-operative Care

One has a tendency at times to forget what is happening to the patient after surgery and yet the after care is extremely important if we are to have a happy patient. Some clinicians are prone to leave off thyroid extract if the basal metabolism is within normal limits. I believe, however, that when we have done a radical subtotal thyroidectomy all of the patients should have thyroid medication of variable amount. It stands to reason that the patient needs thyroid hormone and if it is not given, the pituitary will stimulate the thyroid remnants and undoubtedly may produce sufficient enlargement to cause a recurrence. I doubt if anyone can sufficiently gauge the amount of tissue to be left at operation to keep the patient euthyroid. It seems to me to be wiser to resect radically and give them thyroid extract as needed postoperatively.

Summary

(1) We have presented the various methods in making an accurate diagnosis of hyperthyroidism and special consideration for clinical evaluation of the patient.

(2) A special plea is made to immediately subject patients to surgery when a nodule is found in the thyroid.

(3) A few valuable points in the technique of thyroidectomy are presented.

(4) Treatment of complications following surgery are listed.

Bibliography

1. Transactions of the American Goitre Association, 1953, page 19.
2. To be published in Transactions of the American Goitre Association 1956.
3. Personal communication.
4. Reported at meeting of Southeastern Surgical Congress, Richmond, Va., March 1956.
5. Transactions of the American Goitre Association 1954, page 477.
6. To be published in the Transactions of the American Goitre Association, 1956.

WHAT WOULD I DO IF I HAD AN ULCER?*

by

Lester R. Dragstedt, M.D., Ph.D.

Sometimes it is of value for a surgeon to ask himself just what he would do if he had the lesion that he has found in his patient and had available medical and surgical care of the same competence. Some reflection on this problem has prompted me to write this comment.

Duodenal Ulcer

If I had a duodenal ulcer I would place myself in the hands of a competent internist, preferably one with a special interest in gastrointestinal diseases. I would follow his prescribed management and exercise all of the self-discipline in this connection that I could muster. If he did not make quantitative measurements of my fasting nocturnal gastric secretion I would request that this determination be done. If I discovered that my stomach secreted in excess of 75 mEq. of free hydrochloric acid in a 12 hour period as compared with the normal, 15 to 20, I would conclude that my problem was a serious one and that medical management might well prove inadequate. If my physician did not prescribe neutralization therapy during the night I believe that I would set my alarm clock to awaken me at the period of maximum secretion when I would partake of a mixture of milk and cream with some calcium carbonate. I would continue with medical management for at least a year unless some serious complication developed. If at the end of this time I found that I was still handicapped by my disease, was less efficient in my work, and had to deny myself too much of the pleasures of life, I would then seek surgical treatment. Since it is my own stomach that we are considering now, I would select first that type of surgery which carried the least hazard, involved the least mutilation, and still provided a good chance to be free of my disease. I would choose to have a supradiaphramatic vagotomy by the abdominal route combined with the posterior gastroenterostomy with a stoma not larger than two centimeters in diameter and located within seven centimeters of the pylorus. I would beg the surgeon to make a meticulous dissection of the lower two inches of my esophagus in an effort to make sure that all vagus fibers were divided. I would also request him to decompress my stomach for the first five days after the operation by means of a gastrostomy tube placed in the fundus of the stomach and covered with omentum. I believe that duodenal ulcers are due to a hypersecretion of gastric juice in the empty stomach dependent upon excessive and abnormal secretory impulses in the vagus nerves. These in turn, I believe, are in some way aroused by the tensions and strain of modern life. I would feel greatly relieved if during the first five days after the operation, when my stomach was being decompressed by the gastrostomy tube, the output of free acid in each 12 hour aspirate was less than 10 or 15 mEq. I would feel still better if on the tenth day after the operation the amount of acid in my 12 hour nocturnal secretion was less than 15 mEq. I would then have the tube removed if my stomach was now emptying satisfactorily.

*From the Department of Surgery of The University of Chicago.

I would have my nocturnal gastric secretion measured again at the end of six months and also after a year, particularly if any ulcer symptoms persisted. If the nocturnal secretion was still within normal limits and the stomach emptying satisfactorily, I would be comforted in the thought that in all probability I was now cured of my disease. If, however, I had a recurrence of ulcer symptoms, and my own experience has indicated that this is usually due to an incomplete vagotomy or to an inadequate drainage operation, I should resume medical management. Sometimes medical treatment that was inadequate at first becomes sufficient after an incomplete vagotomy, indicating that some good was accomplished by the operation. If, however, medical treatment again proved inadequate and further surgery was required, I would now choose to have a two-thirds gastric resection with reconstruction of my gastrointestinal tract by the Billroth II operation.

Gastric Ulcer

If I had a gastric ulcer, my choice of therapy would be quite different because I am convinced that these lesions are usually due to a hypersecretion of gastric juice of humoral or hormonal origin and the possibility of malignancy would effect all decisions. I would place myself in the hands, again, of a competent internist and I would be considerably relieved if after his careful study and fluoroscopic examination, possibly supplemented by a short period of medical management, he concluded that my ulcer was benign. I would be still further relieved if exfoliative cytology failed to reveal the presence of malignant cells. I am uncertain as to whether or not I would subject myself to a gastroscopic examination. If after a period of three or four months of medical management I was still not free of symptoms, my anxiety would return that the lesion might be a carcinoma. If the ulcer was located in the lower half of the stomach I would elect to have a subtotal gastric resection with reconstruction by the Billroth I method if possible. If subsequent examination of the lesion indicated that it was benign I would feel greatly relieved, since the development of marginal ulcer after resection of the lower part of the stomach for gastric ulcer is very rare. If examination proved the lesion to be a carcinoma, I would realize that something, although perhaps not very much, had been done for me in the way of therapy.

If the ulcer was in the upper half of the stomach and within a centimeter or two of the esophagus, the problem would be quite different. At operation I would request the surgeon to open my stomach and inspect the lesion if at all possible. I should like him to palpate the ulcer with his bare finger and take a biopsy of a suspicious nodular area. In the absence of histological proof that the ulcer was a carcinoma, I would not wish to have a cancer operation, which in this case would mean a total gastrectomy probably with a laparothoracotomy incision. Such an operation is too hazardous and the morbidity too great for nonmalignant disease. A removal of the antrum of the stomach leaving the ulcer in situ would remove the humoral phase of secretion and in all probability permit the ulcer to heal. The experience with this Kelling-Madlener procedure has been most reassuring and physiological studies support this belief.

Manuscript Memos

Manuscripts should be submitted in duplicate to the Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month — day of month if weekly — and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in the Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, the Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The By-laws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The by-laws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to the Journal of the Kentucky State Medical Association, 620 South Third Street, Louisville 2, Kentucky.

ACHROMATIC



ACHROMYCIN*

Tetracycline *Lederle*

for prophylaxis and treatment of

obstetric infections

Posner and his colleagues[1] have reported on the use of tetracycline (ACHROMYCIN) in 96 cases of obstetric complications, including unsterile delivery, premature rupture of the membranes, endometritis, parametritis, and other conditions. They conclude that this antibiotic is ideally suited for these uses.

Other investigators have shown ACHROMYCIN to be equally useful in surgery and gynecology and virtually every other field of medicine. This outstanding antibiotic is effective against a wide variety of infections. It diffuses and penetrates rapidly to provide prompt control of infection. Side effects, if any, are negligible.

Every gram of ACHROMYCIN is made in Lederle's own laboratories and offered *only* under the Lederle label—your assurance of quality. It is available in a *complete* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection, bolsters the patient's natural defenses, thereby speeds recovery. Especially useful in severe or prolonged illness. Stress formula as suggested by the National Research Council.

SF Capsules, 250 mg.

SF Oral Suspension, 125 mg. per teaspoonful (5 cc.)

For more rapid and complete absorption. Offered only by Lederle!

dry-filled sealed capsules

[1]Posner, A. C., *et al.;* Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

PHOTO DATA: SPEED GRAPHIC CAMERA, F.16, 1/50 SEC., ROYAL PAN FILM

CASE DISCUSSIONS

A CASE OF IMPERFORATE ANUS
FROM THE UNIVERSITY OF LOUISVILLE HOSPITALS
LOUISVILLE CHILDREN'S HOSPITAL

Presentation of the Case

A nineteen day old white female, weighing six pounds fifteen ounces, was admitted to the Children's Hospital May 12, 1955 with the chief complaint of vomiting brown material and having constipated stools per vagina. Her birth weight was seven pounds six ounces. An imperforate anus and recto-vaginal fistula were noted at birth but the fistula was believed to be compatible with life. At seven days of age she developed an intestinal obstruction and was temporarily relieved with enemas and milk of magnesia. At thirteen days of age she again became obstructed and was again successfully treated with enemas. On May 10, 1955, at seventeen days of age an operation was done in the operating room. An incision was made from the fistulous tract in the vagina posteriorly to the spincter ani muscle. During the following twenty-four hours she had six stools undescribed and her condition improved. At 5:45 P.M. on May 12 she began vomiting brown fecal material and was transferred to Children's Hospital.

Management

On admission the patient was distended and slightly dehydrated. Peristalsis were hyperactive. X-rays supported the clinical impression of a low intestinal obstruction. Her condition as recorded by the ward nurse was fair. After giving intravenous blood, electrolyes and antibiotics and having the stomach emptied, a transverse colostomy was done. She was discharged nine days later.

The youngster was readmitted for five days as a feeding problem when she was four months of age. At this time she weighed nine pounds twelve ounces.

At six months of age the patient was readmitted to correct her abnormalities. On October 18, 1955, an abdomino-perineal pull-through procedure was done and on October 28, 1955, an anoplasty, appendectomy, closure of colostomy and excision of hemangioma of abdominal wall were performed. She was discharged on November 7, 1955, in excellent condition.

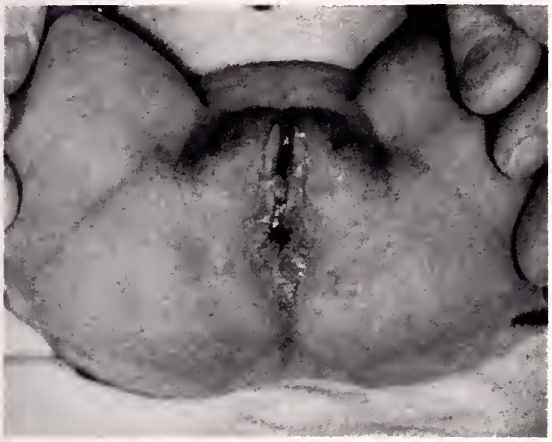
The baby's last visit to the hospital was on June 7, 1956, at which time she had a perfectly normal appearing anus with a small amount of scar tissue around it. Her stools are of normal caliber and her mother is extremely pleased with the final result.

Discussion

B. J. Schoo, M.D.: This patient illustrates many points about imperforate anus which any physician encounters who has dealings with newborn babies: a) She falls into the group of imperforate ani which have a fistulous tract. The sex distribution for imperforate ani is about equal and about 75 per cent of all imperforate ani have a fistulous tract and about 80 per cent of these are females. b) The fistulous tract was not large enough to be compatible with life so that constipation caused intestinal obstruction. This is common. The tract should not be torn or incised but an anoplasty performed. c) Almost every imperforate anus with a low fistulous tract into the vagina, fossa navicularis or perineum can be repaired within

*Hospital Proctocol No. 35981

the first few days of life from the perineal approach alone unless they have had some meddlesome surgery which is incomplete and causes scarring. d) Forty per cent of these patients have other congenital anomalies, the most important and most common ones being congenital heart disease, esophageal atresia and malformations of the vertebrae. This patient had failure of fusion of the thoracic spines of T-5 to T-8, deformity of the left kidney calyces and a hemangioma of the abdomen. Every child with an imperforate anus should have a naso-gastric tube inserted and careful auscultation of the heart. e) The photograph is not of this patient, but demonstrates an imperforate anus with a rectoperineal fistula. This fistulous tract is just anterior to the sphincter ani muscle and this patient would never have bowel control. This is frequently overlooked during a quick examination and the patient is punished severely in later years when she should be developing bowel control and can't. f) The x-ray illustrated shows the distance between the rectum and the imperforate anus. Usually there is no value in taking an x-ray until the child is twenty-four hours of age because it takes this length of time for air to pass along the bowel through the thick meconium to the rectal pouch. This distance determines whether the corrective procedure can be done from a perinal approach alone or whether an abdominal operation will be necessary.





H. B. Lynn, M.D.: It may be worthwhile emphasizing the point that Dr. Schoo has just made about the taking of x-rays in the first few hours of life. It has been our experience that these x-rays serve little or no useful purpose since they either mislead the responsible surgeon or must be repeated just prior to surgery. Therefore, in case of imperforate anus we make no effort to x-ray the lower intestinal tract until there has been sufficient time for intestinal gas to pass to the lowest point in the patent tract.

It is interesting to note that in my own experience the diagnosis of esophagel atresia with esophago-tracheo fistula has been made at least seven times because the patient was referred to the Surgical Service as a newborn infant with an imperforate anus. The handling of these cases is simple providing the lesion is detected since the primary attack must be on the thorax and the handling of the low intestinal obstruction can be controlled by a colostomy or if the patient's condition warrants it, an anoplasty. It is a most distressing circumstance, however, if a patient survives a surgical procedure for relief of imperforate anus and then is found to have an esophageal atresia. I have personal knowledge of three such cases, none of which survived the second operation.

EDITORIALS

AUXILIARY ACTIVITIES ACCLAIMED

THE WOMAN'S AUXILIARY to the Kentucky State Medical Association has consistently demonstrated the validity of the admonition made popular by a national magazine to "Never underestimate the power of the woman."

An examination of the report by Mrs. R. Ward Bushart, the Auxiliary's 1955-56 president, to the 1956 session of the House of Delegates reveals that our ladies have brought genuine credit to the Kentucky medical profession and themselves at every level from community to national.

The choice of Mrs. Clark Bailey as national vice-president and Mrs. Karl D. Winter as the Southern Regional Public Relations chairman reflects the esteem in which other auxiliaries hold the fine work done by Kentucky.

The scope of our Auxiliary's work may be indicated, but not given its proper due, by an enumeration of topics covered in the annual report. These include the American Medical Education Foundation, benevolence, *The Blue Grass News*, cancer, civil defense, heart, legislation, mental health, nurse recruitment, public relations, rural health, *Today's Health*, tuberculosis and special projects.

Almost all of the Auxiliary's activities are related to public relations and services which demonstrate that all members of the medical family are deeply concerned with the well-being of the people. At the county, district and state levels, they range from the sublime to the earthy in a way that creates good will for the medical profession.

County projects listed in the report included such widely varied activities as a public forum on accident prevention, to the washing of heads of students in a school system confronted with a ring worm epidemic. Many auxiliaries are working on nurse recruitment and have given leadership to formation of Future Nurse Clubs. This work in many instances has taken the highly tangible form of nursing scholarships and loans. Assistance in the legislative field has been substantial.

The detailing of additional accomplishments, including promotion of "Doctors Day," assistance with the McDowell House, sponsorship of a tea for wives and fiancees of senior medical students attending the K.S.M.A. Senior Day program, and the annual speech contest on cancer, would consume even more than the 10 pages used in the Auxiliary's report to the House of Delegates.

Those who take the time to study the report will see, however, that it makes two things crystal clear. When the ladies affiliated with the medical profession undertake a task, they do it well. The doctors of medicine in Kentucky owe a deep debt for their many fine works, all of which spring from an earnest desire to serve the profession.

WHAT DOES "BLUE SHIELD" MEAN TO YOU?

HAVE YOU EVER stopped to ask yourself, doctor, why some 37 million Americans have enrolled in Blue Shield, the medical profession's own approved prepayment program, in a little more than ten years' time?

Blue Shield and its companion, Blue Cross, have accomplished the most stupendous enrollment of any insurance program ever offered the American people—at a minimum of expense and by relatively "low pressure" sales methods. This accomplishment has been possible because there is now an almost universal

desire for protection against the costs of unpredictable illness. The chief reason why so many people have chosen Blue Shield is that they know it is recommended and supported by the medical profession, and most people have confidence in the nation's doctors.

By the same token, more Amercians have chosen Blue Cross than any other hospital insurance program because Blue Cross is sponsored by the hospitals, and the public believes in the integrity and efficiency of our voluntary hospital system.

Doctors and hospitals have created for themselves an immeasurable store-house of good will in these Plans. But the preservation of this great asset depends upon eternal vigilance on the part of physicians and hospitals.

When the doctor speaks well of Blue Shield, when he renders the best service he is capable of rendering to Blue Shield patients, when he tries to conserve the resources of Blue Shield against extravagance or abuse, when he conscientiously fulfills his voluntarily accepted obligation as a Participating Physician, then he is helping to preserve and increase this asset. He is helping to make ever more formidable the shield that protects the freedom of medical practice.

Blue Shield is also a bridge of common interest and mutual benefit between the doctor and his patient—it is evidence to each of the trust and confidence of the other. Blue Shield is an assurance to the patient of prepaid service when he needs it—and to the doctor, it assures prompt reimbursement for his services.

NURSES LOOK AT THE NURSING PROBLEM

IT WAS with great interest that I read the editorial "The Nursing Problem" in the August issue of The Journal. I have discussed the article with the editorial writer and believe there are a number of advancements being made in nursing which should be brought to the attention of the doctors in our state.

We are proud that we have had a legislative program which has been active on a national level. In the 84th Congress we were able to obtain officer status for the male nurse; defeat a legislative measure which would have provided for a federal commission on nursing and to have had written into law a bill which provides for an appropriation of two million dollars for advanced education of nurses in supervisory and teaching positions.

Within the scope of professional nursing we have two types of nurses: one who is called the bedside general duty nurse and the other the head nurses, supervisors, administrators or teachers. Within the field of nursing there are still other members of the nursing team; the practical nurse and the nurses' aides. Each team member has a responsible part to play in providing nursing care for the patient.

The nursing profession has for a long time believed in and worked for the training of practical nurses. The first school of practical nursing was established in Kentucky in 1949. We now have six state approved schools of practical nursing. These schools have graduated approximately 600 practical nurses.

Within the profession, we have established what the nurse believes to be her functions. By this I mean what she should do. These functions were derived after extensive study and research. If nurses practice their profession according to these functions we believe we would be able to provide improved nursing care. This would also result in the nurse using her skills in nursing and not in tasks that could be carried by other hospital personnel. The application of these functions requires the cooperation of doctors, the hospital administrators, and all members of the nursing team.

Let me also point out that one of our biggest problems in nursing is that of low salaries. At the present time the starting salary of the general duty bedside nurse is around $240 per month. In industry and other fields the pay is much better, and it is most difficult to interest our young people in nursing.

The "Nursing Problem" is not a problem of nurses alone. It is one which affects all who rely on nursing service. The problem can be greatly decreased by the cooperative efforts and understanding of all members of the health field.

Cynthia N. Warren, R.N.
Executive Secretary
Kentucky State Association of Registered Nurses

ORGANIZATION SECTION

1956 Annual Meeting News

The 1956 annual meeting ended as we met the deadline for this issue of the Journal. See the November issue for full details.

Diabetes Detection Drive Nov. 11-17, Support Urged

All KSMA members will be asked to again give free urine sugar tests to persons requesting them during National Diabetes Week, November 11-17, according to Carlisle Morse, M.D., Louisville, chairman of the KSMA Diabetes Committee.

Free test materials will be available to physicians for the campaign through their county medical society diabetes committee.

"Reports from county chairmen indicate that the 1956 drive, the sixth sponsored by the KSMA in cooperation with the American Diabetes Association, will again succeed in its dual purpose of diabetes education and discovery of previously unknown diabetics," Dr. Morse said. "When one considers the wide public acceptance given to the drive and to the more than 800 new diabetics discovered through it in the past, he cannot help but recognize the good will this major public service creates."

AMA Clinical Session at Seattle, Nov. 27-30

Clark Bailey, M.D., Harlan, and Vinson Pierce, M.D., Covington, will represent KSMA at the A.M.A. Clinical Session in Seattle, November 27-30. Headquarters will be at the Olympic Hotel.

The technical displays as well as the varied and well-planned scientific programs, which have been focused to the interest of the general practitioner, will be found in the Civic Auditorium.

The 45 papers scheduled deal with fluid balance, urological problems, office psychiatry, varicose veins, fractures, diabetes and heart disease. Such subjects as block anesthesia, treatment of burns, and intestinal obstruction will be presented on television clinics.

KSMA Doctors to be Active at SMA Anniversary Meet

Fourteen KSMA members will participate in the scientific sessions at the Golden Anniversary Meeting of the Southern Medical Association in Washington, D. C., November 12-15, according to A. Clayton McCarty, M.D., Louisville, Councilor, and V. O. Foster, Executive Secretary, Birmingham, Ala.

They include: Walter S. Coe, M.D., and Charles Smith, M.D., Louisville, who will present papers on "Dissecting Aneurysm of the Aorta"; Ephraim Roseman, M.D., Louisville, "Neuropathies"; Alfred O. Miller, M.D., Louisville, "Amplification Fluoroscopy in the Private Office"; John J. Robbins, M.D., Louisville, "Vesicorectostomy."

George C. Sivak, M.D., and Robert Lich, M.D., Louisville, "Renal Infarction"; W. McDaniel Ewing, M.D., Louisville, "The Painful Shoulder"; Henry B. Asman, M.D., Louisville, "Internal Procidentia of the Rectum"; and Rufus C. Alley, M.D., Lexington, "Management of Anterior Rectal Abscesses, Fistulas and Lacerations."

Ephraim Roseman, M.D., Louisville, and Robert Lich, Jr., M.D., Louisville, will lead discussions in orologic studies. Jesshill Love, M.D., Louisville, is vice-chairman of the section on radiology and Robert F. Monroe, M.D., Louisville, is secretary of the section on Obstetrics.

First Blue Shield Forum Attracts Ky. Physicians

The first annual Blue Shield Forum of the Kentucky Physicians Mutual, Inc., was held in Louisville on September 6, according to W. Vinson Pierce, M.D., Covington, KPM president and forum moderator.

Others who participated in the program were: A. B. Barrett, M.D., chairman, KSMA Insurance Committee; F. L. Feierabend, M.D., president, Surgical-Medical Care of Kansas City, Mo.; Ned F. Parish, assistant director Blue Shield Commission; Leo Brown, AMA public relations director; Walter R. McBee, executive director, Group Medical and Surgical Service; Donald Stubbs, M.D.; president, Medical Service of District of Columbia; Layne Tyne, Louisville, Blue Cross-Blue Shield director. Also present were Gant Gaither, M.D., Hopkinsville, KSMA president, and J. Vernon Pace, M.D., Paducah, Chairman of the Council.

Dr. Pierce expressed his satisfaction with the meeting. "All of us were pleased with the results of this first forum," he said. "We were glad to see the number of physicans in attendance and felt that the discussion was very stimulating and informative."

Foreign Training Held Doubtful

An evaluation service to study the professional qualifications of foreign graduates has been proposed, says Willard C. Rappleye, M.D., dean of the faculty of medicine at Columbia University.

The proposal followed Dr. Rappleye's report of an influx into this country of thousands of doctors whose training might be regarded as unsatisfactory. He stated that from 25 to 50 per cent of the house staffs in the U. S. hospitals now are aliens. And he reported a prediction made to him that over 5,000 foreign-trained physicians—many of unapproved schools—would enter the U. S. this year as compared with 6,977 who would graduate from American schools.

Regional Meetings Held to Aid Diabetes Detection

The 1956 KSMA diabetes detection drive, to be held November 11 to 17, was the object of pilot regional meetings in Lexington, August 15, Louisa, August 16, and Bowling Green, September 13. The meetings were conducted, respectively, by Franklin B. Moosnick, M.D., Lexington, Philip Carter, M.D., Louisa, and Carlisle Morse, M.D., Louisville, all members of the KSMA Diabetes Committee.

If the three meetings, at which county medical society diabetes committee chairmen were briefed on the drive, are effective in expanding the detection campaign's usefulness in the counties represented, the KSMA Diabetes Committee will consider their extension to other areas for future drives.

As in previous diabetes detection programs, every KSMA member will be asked to give free urine sugar tests to all persons requesting them during National Diabetes Week.

Defense Dept. Works With States on Medicare Plans

Representatives of state medical societies are being invited to Washington by the Department of Defense to work out state-by-state arrangements for the dependent military care program (medicare) on a basis of individual contracts. Congress has appropriated $75,000,000 for this program, to become effective December 8.

Medical societies in several states have drawn up the type of contracts they consider practical in their areas. The Defense Department task force will use these plans, in cooperation with some of the state societies, to perfect a model state contract. Allocations will be made on a regional basis. A directive has been issued indicating the kind of care to be provided in military and civilian facilities, how patients will be identified, and plans for outpatient care.

State societies have worked out the details of the program they are prepared to operate and their disbursing agents, whether it may be the society itself, Blue Shield, or commercial insurance companies. Acceptable fee schedules have also been planned.

Obesity Risks Discussed on TV by Jefferson County MDs

The danger of obesity and its relation to emotional tension was discussed by a panel of physicians from the Jefferson County Medical Society on WHAS television in Louisville on September 13. The hour-long question-and-answer program prompted so many telephone calls from interested viewers that the panel was able to discuss only about one-tenth of the inquiries.

J. Duffy Hancock, Society chairman and former KSMA president, says this discussion was the first of a series of medical programs his group will present on local television. Plans are being made for spontaneous treatment of various subjects, and lay questions received during the programs will be answered as time permits.

The panel on obesity included: J. Randolph Buskirk, M.D., Robert H. Lehman, M.D., Carlisle Morse, M.D., William R. Gray, M.D., Dietz Wolfe, M.D., and W. C. Gettelfinger, M.D.

Student AMA

Through the cooperation of the KSMA Journal, this column will appear monthly with the express purpose of further introducing the University of Louisville Chapter of the Student American Medical Association to organized medicine in the State, and of publishing for the Kentucky physicians the activities and goals of the medical student through S.A.M.A.

Initially, I would like to state the constitutional object of S.A.M.A.: ". . . to advance the profession of medicine, to contribute to the welfare and education of medical students, to familiarize its members with the purposes and ideals of organized medicine, and to prepare its members to meet the social, moral, and ethical obligations of the profession of medicine."

The activities of S.A.M.A. will be listed here in the hope of eliciting participation and comments from interested physicians.

At the beginning of this school year we started interesting the new students in organized medicine with S.A.M.A. membership and subscription to the KSMA Journal. Of course, the entire student body expressed interest in the State meeting last month.

Robert G. Overstreet
Louisville General Hospital

Expansion Continues in Medical Schools

Enrollment reached a new high of 28,639 students in the nation's medical schools during the year 1955-56. The American Medical Association's council on medical education and hospitals reports that the 1955 entering class of 7,686 students was the largest of all time. Operating budgets soared to the 111-million-dollar mark for the 76 approved four-year and the six with two-year-term schools.

Expansion and construction throughout the United States and Canada endeavored to keep pace with enrollment. Various phases of medical education were broadened, while 33 American and three Canadian schools reported construction projects totalling 110 million dollars were under way.

The trend is expected to continue, with larger classes graduating from the established schools. In addition, seven new schools will be graduating physicians by 1963. Few of the 6,845 graduates of 1956 will begin practice or specialty training immediately, however, as 80 per cent was liable for military service. This obligation is expected to delay private practice for at least three years.

Physicians are Urged to Protect Family Finances

Calling on the general practitioner to assume the role of a medical manager, General Paul R. Hawley, director of the American College of Surgeons, said it is the physician's duty to protect the family's purse as well as its health.

Dr. Hawley cited the danger in leaving the patient to make his own diagnosis and said that when a consultant must be called or a hospital bed provided, the general practitioner should "exert every effort to insure that the charges therefor are consistent with the financial status of the family."

General practitioners and specialists should cooperate, Dr. Hawley continued, to assure the nation's proper medical care. "It is the duty of the specialist," he said, " to return the patient to the referring family physician . . . when need for special care has ended, just as it is the duty of the family physician to call upon the specialist promptly when his services are needed."

11 Hospital Projects Endorsed for US Aid

The State Hospital Advisory Council has approved 11 hospital building projects in Kentucky for $2,700,000 in federal grants under the Hill-Burton Act. The grants will allow for 50 per cent of the cost of each project.

Hospitals on the approved list are: Our Lady of Peace and Norton Memorial Infirmary, Louisville; Methodist Hospital of Kentucky at Pikeville; Knox County Hospital, Barbourville; Methodist Hospital, Henderson; Pineville Community Hospital, Pineville; Our Lady of Mercy Hospital and the Owensboro-Daviess County Hospital, Owensboro; St. Elizabeth Hospital, Covington; Daughters of St. Rita of The Immaculate Heart, Versailles; Kings Daughters Hospital, Ashland.

Action was deferred on proposed grants to the Jewish Hospital, Louisville, to a University of Kentucky hospital at Lexington, and to the Pattie A. Clay Infirmary, Richmond.

The federal money allotted would be spread over two fiscal years, 1956-57 and 1957-58. Although only about $1,000,000 will be available to be spent in this fiscal year, all of the approved projects could get under way, according to Paul A. Hackney, Louisville, secretary of the Advisory Council.

Dr. Burney Replaces Dr. Scheele as Surgeon-General of PHS

Leroy E. Burney, M.D., former Indiana Commissioner of Health, began his new duties as the eighth surgeon general of the Public Health Service on August 8. His four-year appointment by President Eisenhower followed the resignation of Leonard A. Scheele, M.D., from the post to join a pharmaceutical firm.

Dr. Burney received his medical degree from Indiana University in 1930 and was commissioned in PHS in 1932, after completing his internship at the U. S. Marine Hospital, Chicago. His career includes, in addition to his servcie as secretary and state health commissioner in Indiana, his work as assistant chief, PHS division of state relations in Washington during World War II and presidency of the Association of State and Territorial Health Officers.

New Med. Hdqrs. Go Up In South

The Florida Medical Association dedicated its new home at Jacksonville on September 15. Preceding a tour of the efficiently designed headquarters, appreciatory remarks were heard from numerous national, state and local leaders.

The Florida dedication followed similar ceremonies recently held in Mississippi and Tennessee, honoring new medical headquarters in each state. All three buildings were planned by architects mindful of the modern comfort and efficient operation necessary to organizations geared to public service.

A new publication, "The National Plan for Civil Defense Against Enemy Attack," has been announced by the Federal Civil Defense Administration. It embodies a two-fold plan for survival: preparations during the pre-attack period and activity during the emergency period immediately before and after an attack. Copies may be obtained for 55 cents through the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

KSMA Exhibits at State Fair

Immunizations was the theme of the KSMA exhibit at the Kentucky State Fair, September 7-15. The exhibit, which emphasized pre-school immunizations, was a joint project of the Committee on Public Information and Service and the Advisory Committee on Public Health, under the chairmanship, respectively of Richard G. Elliott, M.D., Lexington, and C. C. Howard, M.D., Glasgow.

The KSMA called attention of the public to the exhibit and to other public service activities of the Association in an advertisement in the special edition of *The Courier-Journal*, Louisville, published in commemoration of the opening of the new state fair grounds.

Dr. Schneck Heads HD Div.

Paul E. Schneck, M.D., began his duties as director of the bureau of school health at the Kentucky State Health Department on September 15.

Dr. Schneck recently completed two years of service in the medical corps of the U. S. Air Force in Germany. This tour of duty followed two years of practice as a pediatrician on the staffs of General Hospital and Children's Hospital in Louisville. He is a graduate of the Indiana University School of Medicine, Indianapolis, and interned at Wisconsin General Hospital, Madison, Wis. His residency training was served at Good Samaritan Hospital, Cincinnati, Ohio.



Left to right: R. C. Smith, M.D., Newport, president-elect Campbell-Kenton County Medical Society; Marc J. Reardon, M.D., Covington, vice-president; Nelson Jett, M.D., Florence, 50-year honoree; Hadley Caldwell, M.D., Newport, 50-year honoree; John Cassidy, M.D., Covington, president Campbell-Kenton Co. Medical Society; Morris Garrett, M.D., Covington, secretary-treasurer.

Two MDs Given 50 Year Pins

John Hadley Caldwell, M.D., Newport, and N. A. Jett, M.D., Covington, were presented 50-year service pins by the Campbell-Kenton Medical Society at a dinner in Covington on September 6. Both are native Kentuckians.

Dr. Caldwell, 77, was graduated from the Ohio Medical School in 1906 and completed his internship at the old Good Samaritan Hospital in Cincinnati. Dr. Jett, 79, left the teaching profession in 1902 to enter medical school in Louisville. He, too, was graduated in 1906. Dr. Jett practiced at Milford, Powersville and Brooksville before going to Covington in 1918. Since 1940 he has devoted his time to anesthetics.

Ky. MDs to Attend ACOG Meet

Rudy F. Vogt, M.D., Louisville, chairman of the Kentucky section of the American College of Obstetricians and Gynecologists, and William E. Oldham, M.D., Louisville, vice-chairman, are among a number of Kentucky physicians planning to attend the ACOG Fifth Annual Clinical meeting in Chicago, Ill., on November 7-9.

Prominent national speakers will be heard at round table discussions, breakfast conferences and at the featured "Consultation Hours," including several sessions when specialists are queried. The meeting will be held at the Palmer House.

6th District Physicians Meet

More than 40 physicians and their guests attended the KSMA Sixth District Councilor dinner-meeting at the Helm Hotel, Bowling Green, on September 11.

Kirkland Todd, M.D., a Nashville surgeon, spoke on "Modern Trends in Plastic Surgery." His talk followed a brief business session conducted by Russell Starr, M.D., Glasgow, presiding officer. Physicians of Warren, Edmonson and Butler counties were hosts to the 11 county representation.

Health Dept. Makes Changes

In a recent reogranization of personnel at the State Health Department in Louisville, William F. Lamb, M.D., former deputy State health commissioner, was appointed assistant State health commissioner and will head the bureau of local health, according to Russel E. Teague, M.D., commissioner.

Arthur P. Markendorf, former Louisville-Jefferson County Health Board chairman, has been made executive officer for administration. Among the new division directors are: B. D. King, M.D., maternal and child health; Paul Schneck, M.D., school health; Donald P. Conwell, M.D., tuberculosis control and communicable diseases—the bureau of preventive medicine; Attorneys William A. Lamkin and John P. Godfrey (former director), co-directors of the division of legal services; J. F. Blackerby, statistics and records. By virtue of his office, Dr. Teague is now director of medical licensure.

Heads Ky. ADA Post 3rd Time

Carlisle Morse, M.D., Louisville, has been elected Governor for Kentucky, American Diabetes Association, for the third term, according to Fred Williams, M.D., New York, ADA president.

Dr. Morse was also named to two important committees in the national organization, the finance and the public education and detection committees.

Dr. Witten Speaks to AAGP Group

"State Chapter Publications—Their Importance and Production" was discussed by Carroll L. Witten, M.D., Louisville, before the members of the Officers' Conference of the American Academy of General Practice in Kansas City on September 2.

Dr. Witten is editor of the Kentucky Academy of General Practice Journal, which received the national award as the outstanding state journal of the AAGP. The conference was held in conjunction with the dedication of the national headquarters handsome, new $650,000 building in Kansas City.

Medical-Data Workshop Held

A medical-records workshop for hospital administrators, records specialists, and medical school instructors was held in Louisville on September 12-13. The program featured talks by Frank Gaines, M.D., commissioner of mental health in Kentucky, Donald L. Ford, assistant administrator of Philadelphia Children's Hospital, and Marjorie R. Quandt, Chicago, educational director of the American Association of Medical Record Librarians.

Dr. Foley Honored

A new ward building at Western State Hospital, Hopkinsville, has been named the Foley Building in honor of Floyd K. Foley, M.D., Owensboro. Dr. Foley served as superintendent of the Hopkinsville hospital from 1948 until his retirement in 1953. He also formerly served as superintendent of Eastern State Hospital at Lexington.

AAMA To Meet Oct. 26-28

The American Association of Medical Assistants will hold an organizational meeting in Milwaukee, Wis., on October 26-28. Founded in Kansas City in 1955, this non-profit group is composed of medical assistants whose employment is supervised by doctors of medicine. The AAMA plans to hold a national meeting each fall in October.

Dr. Conwell Named to HD Staff

Donald P. Conwell, M.D., M.P.H., has been appointed director of the bureau of preventive medicine at the State Health Department. A former assistant professor of epidemiology at Tulane University, Dr. Conwell will supervise the divisions of accident prevention, chronic diseases, communicable diseases, laboratories, tuberculosis control and veterinary public health within the bureau.

Blue Shield Ups Pay to MDs

During the first six months of this year the Blue Shield Plan, made possible in Kentucky by its doctors, paid $1,695,101.25 to these doctors for services, according to W. H. Cartmell, M.D., chairman of the Enrollment Committee. This is $627,319.75 more than was paid for the corresponding period in 1955, reports Dr. Cartmell.

His report also shows that the Blue Shield Plan had 436,378 members on June 30, an increase of 31,947 since January 1, and that 355 more firms had made the Plan available to their employees during this six-month period. Dr. Cartmell says that the Blue Shield Plan is becoming increasingly valuable to the people of Kentucky and to the medical profession.

NAC Elects Dr. Shepherd

W. W. Shepherd, M.D., Campbellsville, was elected 1st vice-president of the National Association of Coroners at the group's Seattle convention in August. The NAC voted to include Canadian coroners in its organization and Dr. Shepherd is thus slated to become the first president of this international organization. He was appointed as host of the Association's 1957 convention, to be held in Louisville.

Gastroenterological Meet Set

The American College of Gastroenterology will hold its annual convention in New York on October 15-17, 1956.

Following the convention, the Annual Course in Postgraduate Gastroenterology will take place on October 18-20, also in New York. For further information write to: American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Moody Named to BC-BS Post

Lloyd F. Moody has accepted an appointment as head of the Louisville District of the Hospital Physicians Relations Department of Blue Cross-Blue Shield. Mr. Moody was previously employed in the personnel department of an industrial firm in Louisville.

News Items

Thomas Kirby, M.D., a 1954 graduate of the University of Louisville School of Medicine, is now associated with Richard E. Davis, M.D., in Central City. Dr. Kirby has been practicing at Western State Hospital in Hopkinsville.

Frank Wight, M.D., has become associated with John L. Dixon, M.D., in radiology and roentgenology at the Owensboro-Daviess County Hospital and Our Lady of Mercy Hospital, Owensboro. Dr. Wight was graduated from the University of Louisville School of Medicine in 1952. He interned at Kentucky Baptist Hospital and served a residency of St. Joseph's Infirmary, both in Louisville. Dr. Wight served overseas with the U. S. Army from 1943 to 1945.

William Potter Peak, M.D., has announced his association with A. Clayton McCarty, M.D., Louisville, in the practice of internal medicine and rheumatology. Dr. Peak was graduated from the Unversity of Louisville School of Medicine in 1952, interned at Louisville General Hospital and served a residency at the Veterans Administration Hospital.

Thomas G. Taylor, M.D., who graduated from the Medical College of Georgia in 1955, has begun a practice at Fern Creek. Dr. Taylor served his internship at Columbia Hospital, Columbia, South Carolina.

Paul K. Wellman, M.D., has opened an office in Bowling Green for the practice of ophthalmology. Dr. Wellman was graduated from the University of Pittsburgh School of Medicine in 1947. He interned at Western Pennsylvania Hospital in Pittsburgh and took his specialty training at Tulane University.

T. Garrett Craft, M.D., recently returned to Kentucky after a tour of duty in the U. S. Navy. He will practice in Harlan County. Dr. Craft was graduated from the University of Louisville School of Medicine in 1945.

Roger W. Bumgarner, M.D., anesthesiologist, recently began a practice in Louisville. He graduated from the Washington University School of Medicine in 1949, interned at the University of Kansas Medical

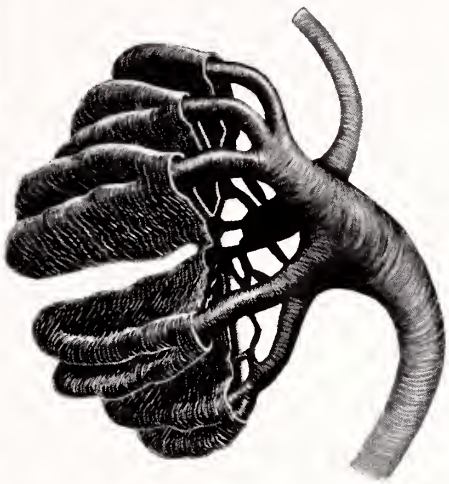
(Continued on Page 884)

NEW AND IMPORTANT

ROLICTON*

(BRAND OF AMINOISOMETRADINE)

Simple b.i.d. Dosage for Positive Diuresis



THE GLOMERULAR FILTERING SYSTEM
Configuration of the renal glamerulus as revealed by the electron microscope.

(illustration by Hans Elios)

THIS newest product of Searle Research is the only *continuously effective* oral diuretic that avoids *all* these disadvantages:

. . . Significant side effects
. . . Complicated dosage schedules
. . . Electrolyte disturbance
. . . Acid-base imbalance
. . . Fastness
. . . Known contraindications

ROLICTON has been found effective as an agent to eliminate, or greatly reduce the frequency of, mercurial injections.

DOSAGE IS SIMPLE. One tablet b.i.d. is usually adequate, following administration of four tablets the first day. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

*Trademark of G. D. Searle & Co.

SEARLE

(Continued from Page 882)

Center, and served a residency at the University of Kansas Medical Center.

Milton O. Beede, Jr., M.D., recently began a practice at Hazel Green, moving from West Liberty. A graduate of Rush Medical College in 1940, Dr. Beede interned at the Station Hospital, Fort Sam Houston, Texas, and served a tour of duty in the U. S. Army.

Marian C. Walton, M.D., Melber, a graduate of Temple University School of Medicine, Philadelphia, in 1953, is on full-time service at the community-sponsored Melber Clinic in Graves County. A native Kentuckian, Dr. Walton formerly practiced at Central City. His internship was served at the Wilson Memorial Hospital, Johnson City, N. Y.

Daniel K. Bloomfield, M.D., is now associated with the Wainer Clinic, Providence. He is a graduate of the Western Reserve School of Medicine in the Class of 1954 and a veteran of service in the U. S. Navy.

Willard M. Buttermore, M.D., ophthalmologist, has removed his office from Harlan to Corbin. Following his graduation from the University of Tennessee College of Medicine in 1939, Dr. Buttermore completed a tour of duty in the U. S. Army. He has practiced in Harlan since 1946.

Richard M. Brandon, M.D., has opened an office in Crittenden. He was graduated from the University of Louisville School of Medicine in 1954 and served his internship at St. Elizabeth's Hospital in Covington. Dr. Brandon practiced at Earlington before moving to Crittenden.

County Society Reports

Scott

The regular monthly meeting of the Scott County Medical Society was held on August 2, 1956 at the John Graves Ford Hospital.

The following physicians were present: J. C. Cantrill, F. W. Wilt, C. R. Lewis, H. G. Wells, A. F. Smith, W. S. Allphin and H. V. Johnson.

William Kafoglis, M.D., and Mr. B. C. Johnson met with the Society. Mr. Johnson gave a talk on polio vaccine.

Motion was made and seconded that the Scott County Medical Society agree as a unit to urge the people of Scott County to have their children immunized against polio, either by their private physcian or at the Wednesday morning clinic at the Scott County Health Department. the motion carried.

Scott

The Scott County Medical Society met in regular monthly meeting on Thursday, September 6, 1956 at the John Graves Ford Memorial Hospital in Georgetown. The following physicians were present: W. S. Allphin, Bedford Brown, J. C. Cantrill, C. R. Lewis, H. G. Wells, F. W. Wilt and H. V. Johnson. Drs. Ralph E. Ellis and O. R. Smith local dentists, met with the Society.

The State Counselor for the Kentucky State Medical Association was expected as a guest, but failed to appear.

Dr. Cantrill gave a report on the State Diabetic Drive Committee. He outlined his plans for a large number of checkups and asked for the cooperation of the doctors.

There being no further business to come before the Society, the meeting was adjourned.

H. V. Johnson, *Secretary*

MONODRAL® WITH MEBARAL®



ANTICHOLINERGIC • SEDATIVE

in peptic ulcer management

- relieves pain promptly
- reduces tension safely
- tranquilizes without dulling
- well tolerated
- promotes healing
- maintains anacidity for hours
- controls hyperactivity of upper gastro-intestinal tract

MONODRAL with MEBARAL—the "psychovisceral stabilizer"—provides for patients with ulcer and gastro-intestinal spasm an effective barrier against the impact of environmental stimuli . . . controls gastric hypersecretion and hypermotility for three and one half to five hours.*

EACH TABLET CONTAINS:
MONODRAL bromide..... 5 mg.
MEBARAL.....32 mg.

DOSAGE: 1 or 2 tablets three or four times daily.
Available on prescription only.
Bottles of 100 tablets.

Winthrop Laboratories New York 18, N. Y.

Monodral (brand of penthienate) and Mebaral (brand of mephobarbital), trademarks reg. U. S. Pat. Off.

**References and clinical trial supplies available on request.*

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 5, 6, 7 and 8, 1957

Palmer House, Chicago

Lectures Daily Teaching Demonstrations

Medical Color Telecasts

The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

"The mercurial diuretics have the justified reputation of being the most powerful and consistently effective of all diuretic drugs."*

TABLET
NEOHYDRIN®

*Gaadman, L. S., and Gilman, A.: The Pharmacalogical Basis of Therapeutics, ed. 2, New Yark, The Macmillan Campany, 1955, p. 847.

07756

In Memoriam

WILLIAM B. MESSINK, M.D.
WORTHVILLE
1869-1956

Dr. Messink, 87, a general practitioner in Carroll County 63 years, died July 15 at his home. His active practice had been reduced to a part-time basis for the past two years following a heart attack.

Dr. Messink was graduated from the Lousiville Medical College in 1892. Soon afterward he began his practice at Carrollton. He delivered more than 2,000 babies during his service there and at Worthville.

J. TOM PRICE, M.D.
HARRODSBURG
1868-1956

Dr. Price, 88, died August 14 at the Haggin Memorial Hospital, Harrodsburg, after a long illness. A former secretary of the Mercer County Medical Society, Dr. Price was a staff member of the old A. D. Price Memorial Hospital in Harrodsburg.

Following service with the Army Medical Corps during World War I, Dr. Price returned to Mercer County to complete 60 years of active practice prior to his retirement in 1955.

WILLIAM E. AKIN, M.D.
PAINTSVILLE
1902-1956

Dr. Akin, 54, died August 2 at the Veterans Hospital, Louisville, where he had been a patient since 1952. A heart ailment forced his retirement from active practice in Eastern Kentucky after a service of 20 years.

A native of Mississippi, Dr. Akin was graduated from the University of Louisville Medical School in 1931. His medical practice in Paintsville was interrupted during World War II when he served as a commander in the U. S. Navy.

JOSEPH W. FITZPATRICK
LOUISVILLE
1875-1956

Dr. Fitzpatrick, 81, died July 25 at his home. He formerly practiced in Anchorage, with offices in his residence there.

A native of Richmond, Dr. Fitzpatrick was graduated from Centre College and received his medical degree from the old Louisville Hospital College of Medicine in 1900. His 56-year practice included service in Middlesboro and in Tennessee prior to his coming to Jefferson County in 1925.

'ANTEPAR'®*



for "This Wormy World"

PINWORMS

ROUNDWORMS

*SYRUP OF 'ANTEPAR' Citrate brand Piperazine Citrate

Bottles of 4 fluid ounces, 1 pint and 1 gallon.

*TABLETS OF 'ANTEPAR' Citrate brand Piperazine Citrate

250 mg. or 500 mg., Scored

Bottles of 100.

Pads of directions sheets for patients available on request.

BURROUGHS WELLCOME & CO. (U. S. A.) INC.
Tuckahoe, New York

HENRY COOK POPE, M.D.
RICHMOND
1881-1956

Dr. Pope, 75, died June 22 in his office at the Pope Hospital of a heart attack. He and his sons, Mason Pope, M.D., and the late R. L. Pope, M.D., opened the hospital in 1940.

A native of Knox County, Dr. Pope was graduated from the Louisville Hospital College of Medicine in 1906. He practiced medicine in Kirksville for 32 years before coming to Richmond.

J. J. McCLENDON, M.D.
RUSSELL SPRINGS
1880-1956

Dr. McClendon, 76, died at his home August 3. A native of Pulaski County, he had practiced medicine at Russell Springs for more than 50 years.

Dr. McClendon was graduated from the Medical Department of Kentucky University, Louisville, in 1907.

F. C. COFFIELD
SALEM
1875-1956

Dr. Coffield, 81, a Marshall County physician for 42 years, died July 10 at a Paducah hospital. He had been in ill health the past two years.

A native Kentuckian, Dr. Coffield was graduated from the Louisville Hospital College of Medicine in 1904. He began his practice in Salem in 1947.

G. WARD DISBROW, M.D.
OWENSBORO
1890-1956

Dr. Disbrow, 66, pathologist and radiologist at the Owensboro-Daviess County Hospital, died July 22 at the hospital. He was a past president and secretary of the Daviess County Medical Society.

A native of New Jersey, Dr. Disbrow was graduated from the University of Maryland Medical College in 1913. He formerly served as an assistant professor of vegetable histology and bacteriology at the New Jersey College of Pharmacy and as a commissioned officer in the U. S. Medical Corps during World War I. He practiced medicine in Summit, N. J. before coming to Owensboro in 1940.

HUGH H. RICHESON, M.D.
LOUISVILLE
1887-1956

Dr. Richeson, 69, an eye-ear-nose-and-throat specialist for 30 years, died July 24 at the Kentucky Baptist Hospital. He had served on the staffs of the Kentucky Baptist and Children's Hospitals.

Dr. Richeson received his medical degree from the University of Louisville Medical School in 1914. Following a tour of duty in World War I he commenced active practice which continued until his retirement in 1955 due to ill health.

IN MEMORIAM (continued)

FRANK VERNON, M.D.
Pikeville
1910-1956

Dr. Vernon, 46, was killed in an automobile accident at Elkhorn City on September 9. He was a surgeon on the staffs of the Methodist and United Mine Workers Hospitals, having practiced at Pikeville since 1939.

Dr. Vernon was graduated from the University of Georgia Medical Department in 1935.

JAMES A. OUTLAND, M.D.
Murray
1884-1956

Dr. Outland, a public health officer for the past 25 years, died August 24 at his home at Murray after an illness of two weeks. He was 71.

Dr. Outland had practiced medicine for more than 40 years in Calloway County. He was graduated from the University of Louisville School of Medicine in 1912.

ALBERT T. ROLL, M.D.
Louisville
1881-1956

Dr. Roll, 76, died August 23 at the Jewish Hospital in Louisville. He had been a practicing physician on the staff of the Veterans Administration Hospital, Louisville, for the past ten years, following a practice of 30 years in Hilo, Hawaii.

A native of Fredericksburg, Ind., Dr. Roll was graduated from the University of Louisville Medical School in 1916.

HANSFORD H. BUNTIN, M. D.
Carlisle
1869-1956

Dr. Buntin, 87, died September 4 after a short illness. He was Nicholas County's oldest physician, having practiced there since 1891, the year in which he was graduated from the Kentucky School of Medicine, Louisville.

M. E. CROFT, M.D.
Hopkinsville
1875-1956

Dr. Croft died at a Hopkinsville hospital September 13. He was 81 years of age and had been a practicing physician of Christian County for 56 years.

Dr. Croft graduated from the Louisville Hospital College of Medicine in 1902.

Results With

'ANTEPAR'®*

against PINWORMS

In clinical trials, over 80% of cases have been cleared of the infection by one course of treatment with 'Antepar.'

Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

against ROUNDWORMS

"Ninety per cent of the children passed all of their ascarides . . ."

Brown, H. W.: J. Pediat. 45:419, 1954.

*SYRUP OF 'ANTEPAR' Citrate brand Piperazine Citrate

Bottles of 4 fluid ounces, 1 pint and 1 gallon.

*TABLETS OF 'ANTEPAR' Citrate brand Piperazine Citrate

250 mg. or 500 mg., Scored

Bottles of 100.

Pads of directions sheets for patients available on request.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, New York

PERTINENT PARAGRAPHS

Milton Golin, Chicago, has joined the A.M.A. Journal staff as an assistant to Editor Austin Smith. His reporting will deal primarily with significant non-scientific developments in medicine. Golin has been a newspaperman since 1942.

The International Medical Assembly, a teaching program offered by the Interstate Postgraduate Medical Association of North America, will be held at the Municipal Auditorium, Cleveland, Ohio, on October 22-25, 1956. This concentrated scientific meeting has been approved by the A.A.G.P. Educational Committee for 26 hours of Category II credit. The program has been arranged to meet the needs of progressive specialists and general practitioners desiring to keep abreast of medical advances that affect their practice.

The annual report of Blue Cross to North America shows that an all-time high of $895 million for all Plans was paid to subscribers in 1955. This was almost 92 per cent of earned subscription income. The balance was divided as follows: 6.33 per cent for operating expenses and 2.33 per cent for reserves.

A course in electrocardiology will be presented December 3-7, 1956 in Houston, Texas, under auspices of the University of Texas Postgraduate School of Medicine and Baylor University College of Medicine. Individual instruction in reading electrocardiograms will be provided. For further information write: The University of Texas Postgraduate School of Medicine, Texas Medical Center, Houston 25, Texas.

The total population of Kentucky's four mental hospitals decreased by 405 patients during the fiscal year 1955-56, reports Frank M. Gaines, M.D., commissioner of mental health. He attributed the drop to (1) improved hospital personnel, (2) greater use of tranquilizing drugs. Despite the decrease, however, Dr. Gaines said that 300 more persons were admitted to the institutions during this period and that crowded conditions still exist.

Benjamin M. Duggar, M.D., 84, of Pearl River, N. Y., discoverer of the "wonder drug" aureomycin, died September 10. A retired college professor, Dr. Duggar had been a research chemist for the past 13 years at Lederle Laboratories, New Haven, Conn.

"the most critical inspection yet devised for an eye-glass lens"--

Your prescription filled by us will be processed to the prescription with first quality materials; the glass and surfaces will be tested for precision of workmanship—and your lenses checked for accuracy of power —only a perfect lens passes the Southern Optical test.



Southern Optical COMPANY

CONTACT LENSES
(Fluidless Lacrilens—Microlens)

ARTIFICIAL EYES
(Custom Plastic—Glass)

HOME OWNED SINCE 1897

4th and Chestnut
334 W. Broadway
LOUISVILLE

GUILD OPTICIANS

Relax the best way ... pause for Coke



continuous quality is quality you trust

DRINK Coca-Cola
REG. U.S. PAT. OFF.

Medica-legal problems will be featured in a series of films to be produced by the William S. Merrell Company, a pharmaceutical firm of Cincinnati, in cooperation with the law department of the American Medical Association. The first film will be reviewed at the AMA's Clinical Session next month in Seattle. It shows a doctor as a medical expert witness. State and county medical societies will be able to obtain the film for showing after December 15.

Vester A. Jacksan, M.D., Clinton physician for 11 years, is terminating his Kentucky practice to move to Los Angeles, Calif., where he will open a new office. A graduate of the University of Louisville School of Medicine in 1941, Dr. Jackson interned at Louisville General Hospital. He served three years in the Army Medical Corps during World War II.

American management is increasing its cantributions to colleges and universities, reports the Council for Financial Aid to Education. A non-profit organization of business men and educators, the CFAE noted in a survey the increasing number of unrestricted grants, leaving the schools free to decide the use of their money. The principal limitation is that the money be used for current expenses, through which professors' salaries is a big item.

PLEASE NOTICE

Advertising space in The Journal of the Kentucky State Medical Association is worth just what you make it. All advertisements appearing in The Journal have been carefully screened in order that our readers may depend on them. When you buy from firms advertising in The Journal you protect yourself against questionable products and you increase the value of this, your own Journal, to its advertisers. Remember this, and use these pages as your buying guide.



Q: *In x-ray equipment what will $4950 buy?*

A: This new G-E PATRICIAN

complete with 200-ma control and transformer

YOURS . . . General Electric quality . . . complete diagnostic x-ray unit with tilt table . . . combined facilities for fluoroscopy and radiography—all for just $4950, f.o.b. Milwaukee, U.S.A.

New PATRICIAN gives you 81-inch angulating table . . . independent tubestand with choice of floor-to-ceiling or platform mounting . . . 200-ma, 100-kvp, full-wave transformer and control . . . double-focus, rotating-anode tube.

Also, you get counterbalanced automatic Bucky, plus fluoroscopic screen that's also counterbalanced, self-retaining in all table positions. You can take cross-table and stereo views. Focal-film distances range up to a full 40 inches at any table angle . . . as great as 48 inches cross-table.

The new PATRICIAN can be yours on liberal purchase terms . . . or can be leased under the popular G-E Maxiservice® *rental* plan. Ask your General Electric x-ray representative for all the facts.

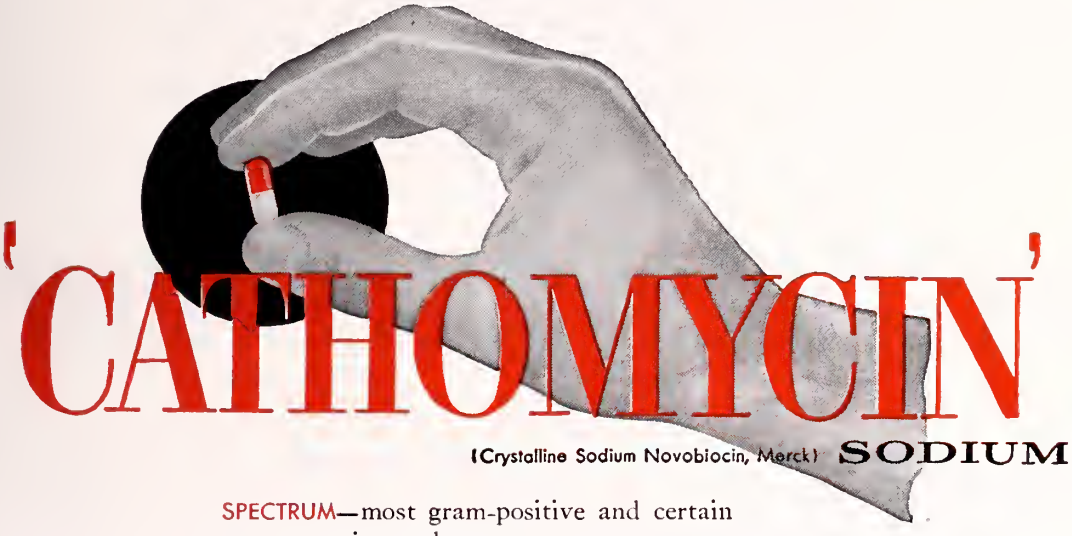
Progress Is Our Most Important Product

GENERAL ELECTRIC

NOW AVAILABLE...

a unique new antibiotic of major importance

PROVED EFFECTIVE AGAINST SPECIFIC ORGANISMS
(staphylococci and proteus)
RESISTANT TO ALL OTHER ANTIMICROBIAL AGENTS



'CATHOMYCIN'

(Crystalline Sodium Novobiocin, Merck) SODIUM

SPECTRUM—most gram-positive and certain gram-negative pathogens.

ACTION—bactericidal in optimum concentration even to resistant strains.

TOXICITY—generally well tolerated. This is more fully discussed in the package insert.

ABSORPTION—oral administration produces high and easily-maintained blood levels.

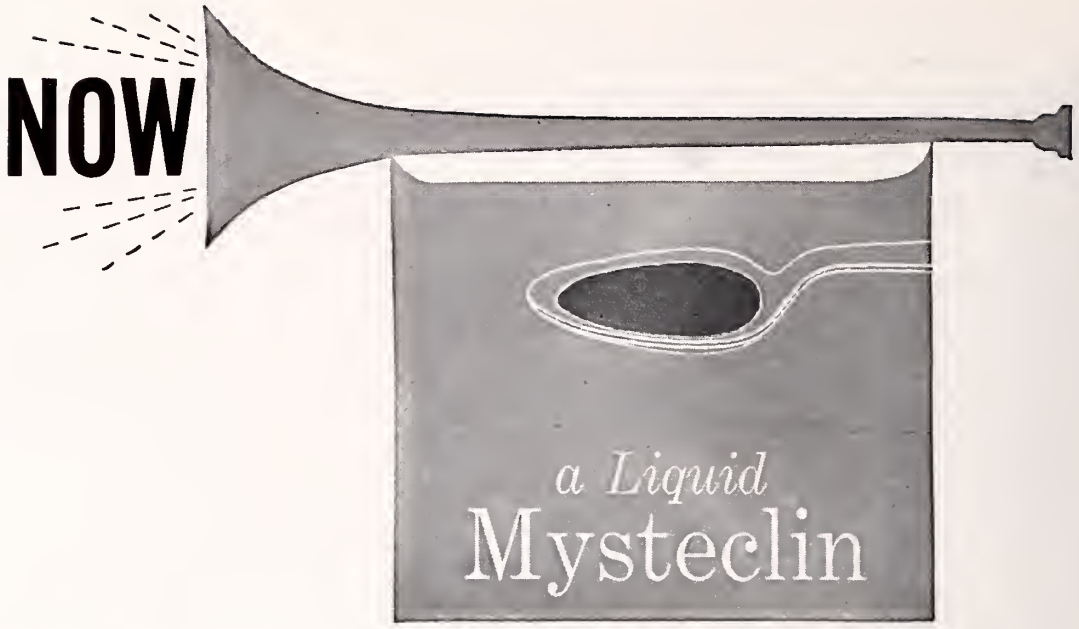
INDICATIONS—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris;* including strains resistant to all other antibiotics.

DOSAGE—Two capsules (500 mg.) twice daily or one capsule (250 mg.) four times a day.

SUPPLIED—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

'CATHOMYCIN' *is a trademark of Merck & Co., Inc.*

MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.



MYSTECLIN SUSPENSION

Steclin-Mycostatin (Squibb Tetracycline-Nystatin)

Another form of the only broad spectrum antibiotic preparation with added protection against monilial superinfection

PLEASANT TASTING — Mysteclin Suspension is pleasantly fruit-flavored and will appeal to taste-conscious youngsters as well as to adults who prefer liquid medication.

BROADLY EFFECTIVE — Mysteclin Suspension provides well tolerated therapy for the many common infections which respond to tetracycline—and also acts to prevent monilial overgrowth.

READY-TO-TAKE — Mysteclin Suspension requires no reconstitution and can be given by simple teaspoon dosage to patients of all ages.

MYSTECLIN SUSPENSION: a fruit-flavored oil suspension containing the equivalent of 125 mg. Steclin (Squibb Tetracycline) Hydrochloride and 125,000 units Mycostatin (Squibb Nystatin) per 5 cc. teaspoonful. Supplied in two-ounce bottles.

Also available as Capsules (250 mg. Steclin Hydrochloride and 250,000 units Mycostatin) and Half Strength Capsules (125 mg. Steclin Hydrochloride and 125,000 units Mycostatin).

SQUIBB *Squibb Quality — the Priceless Ingredient*

"MYSTECLIN"®, "STECLIN"®, AND "MYCOSTATIN"® ARE SQUIBB TRADEMARKS

Journal Report:

Hypertensive symptoms relieved in 96% of patients

"Comparison of pentolinium [ANSOLYSEN] with other preparations in 25 patients with severe essential hypertension, for whom all other methods of management had failed, showed that pentolinium is the most effective of available agents in reducing dangerously high blood pressure to the desired levels, and in modifying some of the complications of hypertension, as cardiac decompensation, cardiomegaly and retinopathy. . . .

"In 96 per cent (24 patients) clinical symptoms were relieved and the blood pressure maintained at comfortable levels. . . ."[1]

ANSOLYSEN®

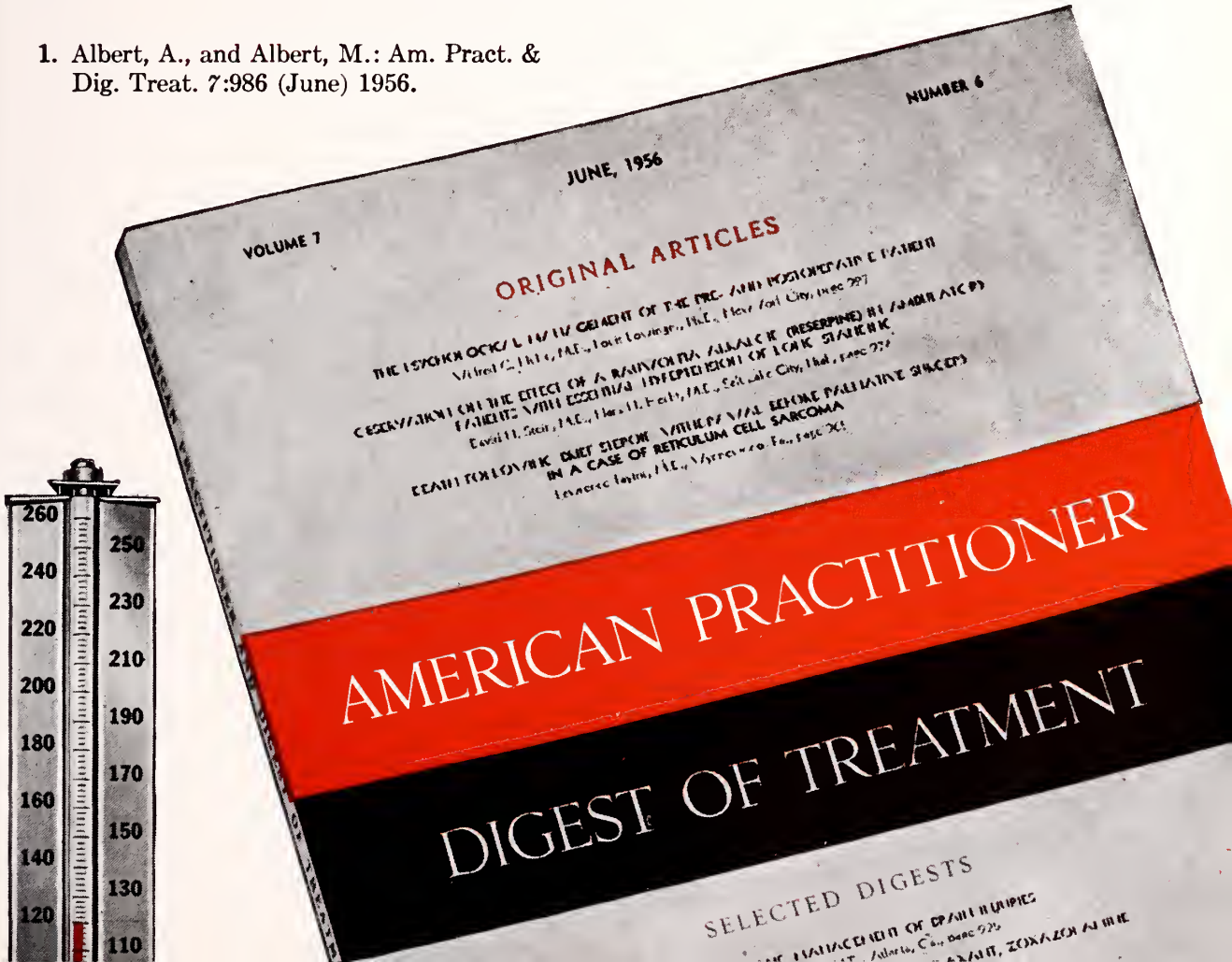
TARTRATE

Pentolinium Tartrate

Lowers Blood Pressure

Wyeth®
Philadelphia 1, Pa.

1. Albert, A., and Albert, M.: Am. Pract. & Dig. Treat. 7:986 (June) 1956.



Combined for a

on

resistant

new

METRETON tablets

METICORTEN (PREDNISONE) PLUS CHLOR-TRIMETON WITH ASCORBIC ACID

For prompt and effective relief, especially in many resistant allergic disorders, METRETON affords the benefits of two established agents with unexcelled anti-inflammatory, anti-allergic and antipruritic effectiveness. *supported by essential vitamin C*—for stress support and for postulated effect on prolonging steroid action *no better corticosteroid*—original brand of prednisone...minimal electrolyte effects—METICORTEN *no better anti-histamine*—unexcelled in potency and freedom from side effects—CHLOR-TRIMETON effective against hay fever, pollen asthma, perennial rhinitis, acute and chronic urticaria angioneurotic edema, drug reactions, inflammatory and allergic eye disorders, pruritic and contact dermatoses.

formula: Each tablet of METRETON provides 2.5 mg. of METICORTEN (prednisone), 2 mg. of CHLOR-TRIMETON maleate (chlorprophenpyridamine maleate), and 75 mg. ascorbic acid.

supplied: METRETON Tablets, bottles of 30 and 100.

frontal attack

allergies

new

METRETON nasal spray

METICORTELONE (PREDNISOLONE) PLUS CHLOR-TRIMETON

Quickly clears nasal passages • avoids rebound engorgement and sympathomimetic side effects • safe even for cardiacs, hypertensives, children, pregnant patients •

Composition: Contains 2 mg. (0.2%) METICORTELONE acetate (prednisolone acetate) and 3 mg. (0.3%) of CHLOR-TRIMETON gluconate (chlorprophenpyridamine gluconate) in each cc.

Packaging: 15 cc. plastic "squeeze" bottle, box of 1.

METRETON,* brand of corticoid-antihistamine compound; METICORTEN,* brand of prednisone; METICORTELONE,® brand of prednisolone; CHLOR-TRIMETON,® brand of chlorprophenpyridamine preparations. *T.M.

MT-J-576



Schering

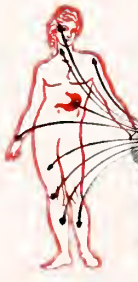
in inflammatory skin diseases



all the benefits of the "predni-steroids"
plus positive antacid action
to minimize gastric distress

ROUTINELY ACHIEVED WITH

'Co-Deltra'
(Buffered Prednisone)



Multiple Compressed Tablets



'Co-Hydeltra'
(Buffered Prednisolone)

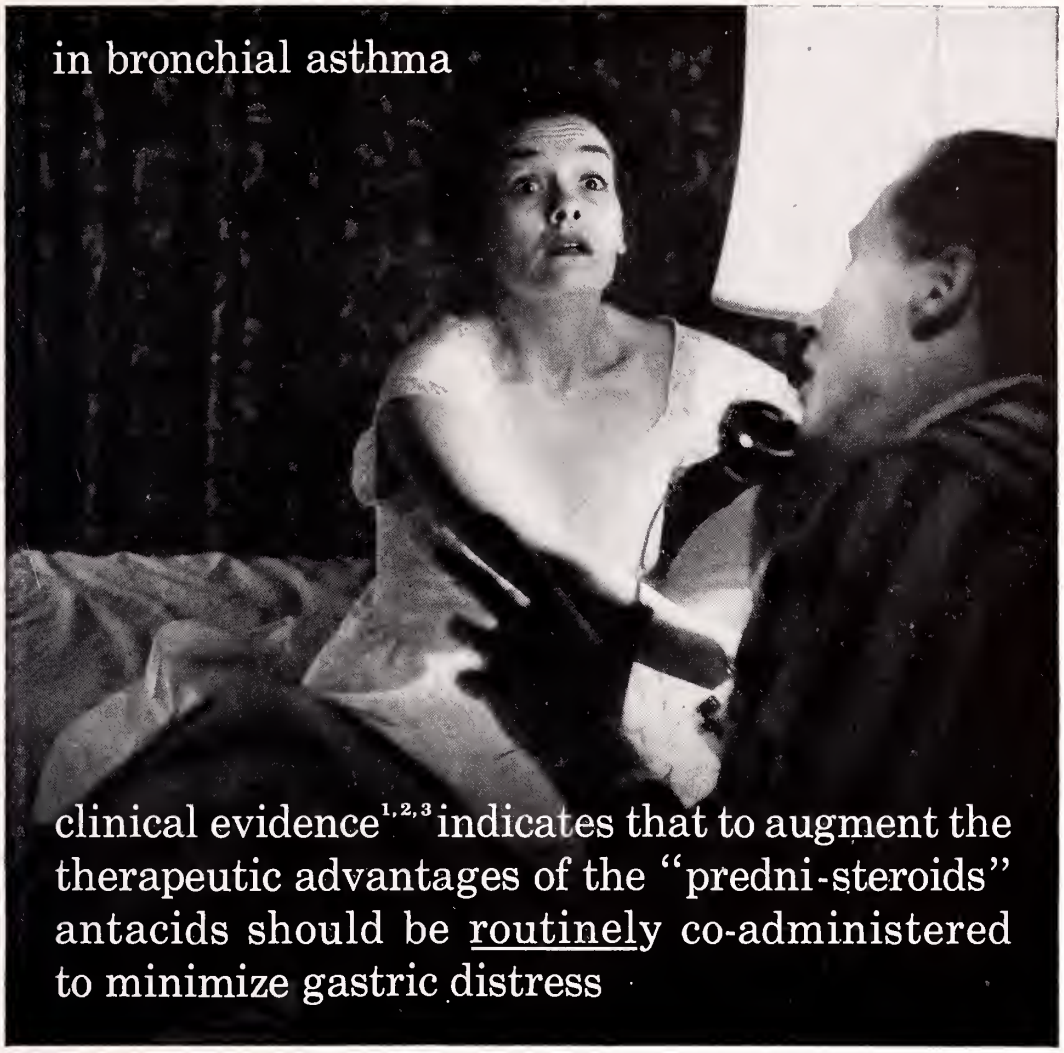
2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

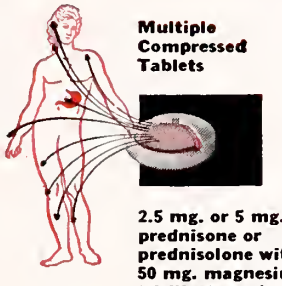
MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are the trademarks of* MERCK & CO., INC.



ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Buffered Prednisolone)



Multiple Compressed Tablets

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

'Co-Deltra'
(Buffered Prednisone)

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al, J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al, J.A.M.A.* 158:459, (June 11,) 1955.

MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are the trademarks of* MERCK & CO., INC.

CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of
mental and nervous disorders, and
addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director

WAYSIDE HOSPITAL

168 North Broadway
Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

APPROVED BY AMERICAN MEDICAL ASSOCIATION

STAFF

H. HALBERT LEET, M.D. — JOHN H. ROMPF, M.D.
CARL WIESEL, M.D. — IRVING A. GAIL, M.D.
EDWARD L. HOUCHIN, ADMINISTRATOR

Phone: 2-2050

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)
(The Pioneer Postgraduate Medical Institution in America)

OBSTETRICS AND GYNECOLOGY

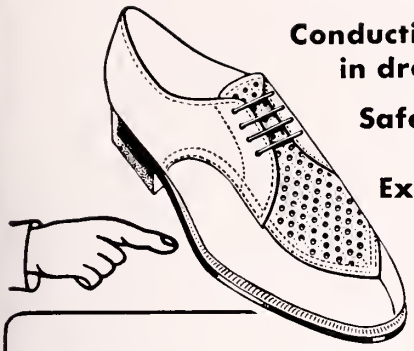
A two months full time course. In Obstetrics: lectures; prenatal clinics; attending normal and operative deliveries; detailed instruction in operative obstetrics (manikin). X-ray diagnosis in obstetrics and gynecology. Care of the newborn. In Gynecology; lectures; touch clinics; witnessing operations; examination of patients preoperatively; follow-up in wards post-operatively. Obstetrical and gynecological pathology. Culdoscopy. Studies in Sterility. Anesthesiology. Attendance at conferences in obstetrics and gynecology. Operative gynecology on the cadaver.

SURGERY AND ALLIED SUBJECTS

A combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastroenterology, proctology, gynecological surgery, urological surgery. Attendance at lectures, witnessing operations, examination of patients pre-operatively and post-operatively and follow-up in the wards post-operatively. Pathology, radiology, physical medicine, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology, orthopedics. Operative surgery and operative gynecology on the cadaver; attendance at departmental and general conferences.

For Information about these and other courses Address:

THE DEAN, 345 WEST 50th St., New York 19, N. Y.



Conductive Shoe in dress style

Safety from Fire and Explosion★

- Insole extension and wedge at inner corner of heel where support is most needed.
- The patented arch support construction is guaranteed not to break down.
- Innersoles guaranteed not to crack or collapse.
- Foot-so-Port lasts designed and the shoe construction engineered with orthopedic advice.

★ Conductive Shoes for surgical and operating room personnel. N.B.F.U. specifications.

- We are also the manufacturer of the Gear-Action Shoe designed by noted orthopedic surgeon.
- We make more shoes for polio, club feet and disabled feet than any other shoe manufacturer.

Send for free booklet, "The Preservation of the Function of the Foot Balancing and Synchronizing the Shoe with the Foot."

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.
A Division of Musebeck Shoe Company

Malpractice Prophylaxis

With us
freedom from group involvements
in insurance functions brings far
less malpractice litigation than
prevails elsewhere

Specialized Service makes our doctor safer

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively
since 1899

LOUISVILLE Office
Calvin Bimer, Representative
3119 Hewitt Ave.
Tel. Glendale 8-3060
If no answer, call Clay 3636

EVERY WOMAN
WHO SUFFERS
IN THE
MENOPAUSE
DESERVES
"PREMARIN"®

widely used
natural, oral
estrogen

AYERST LABORATORIES
New York, N. Y. • Montreal, Canada
5646



broad-spectrum therapy as good as it tastes!

TETRABON*

BRAND OF TETRACYCLINE HOMOGENIZED MIXTURE

125 mg. tetracycline per 5 cc. teaspoonful. Bottles of 2 fl. oz. and 1 pint, packaged ready to use (no reconstitution required).
READILY ACCEPTED delightfully different fruit flavor . . .
RAPIDLY ABSORBED fine particle dispersion—therapeutic blood levels within one hour . . .
QUICKLY EFFECTIVE well-tolerated tetracycline for prompt control of a wide range of infections.

*Trademark

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, N.Y.

Pfizer

WANTED
GENERAL PRACTITIONER
OR INTERNIST
To occupy unit in suite
of downtown Louisville office,
656-660 Francis Building.
Leased by
established Surgeon-Gynecologist.
UNUSUAL OPPORTUNITY!
Phone Ju 4-3614

Choice location for general practice. A recent death makes office with adjacent home in separate building available. Small town atmosphere. The one other physician in town welcomes help. Practice should be assured immediately. Nine miles from county hospital and about 35 from the Jeffersonville bridge. Ideal for individual who needs immediate practice and yet desires to retain Louisville connections.

Contact:
MRS. FRANK GREEN, Rushville, Indiana

NEW CASTLE SANITARIUM

Telephone 3621
NEW CASTLE, KY.

For the care of
CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the American Hospital Association
Member of the American Assn. of Nursing Homes
Licensed and Approved by the State of Kentucky

SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE
PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS
24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES
New Selectemp Moduloted Steam Heat With Filtered Air
For Maximum Comfort and Safety
Protected Throughout With Automatic Fire Detection and Alarm System

IRA O. WALLACE, Administrator



the Emblems of RELIABLE PROTECTION

We cordially invite your inquiry
for application for membership
which affords protection against
loss of income from accident and
sickness as well as benefits for
hospital expenses for you and
all your dependents

ALL PREMIUMS COME FROM
PHYSICIANS SURGEONS DENTISTS
ALL BENEFITS GO TO

$4,500,000 ASSETS
$23,800,000 PAID FOR BENEFITS SINCE ORGANIZATION

Since 1902

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA



excellent

remedy

for a

poor

appetite

INCREMIN*

Lysine-Vitamin Drops

- combines the amino acid, l-Lysine, with vitamins B_1, B_6, B_{12}
- stimulates appetite, effects better utilization of protein, thereby promoting growth
- cherry-flavored drops are delicious; may also be mixed in milk, formula, etc.
- handy 15 cc. plastic dropper-bottle

For the problem eaters, for the underweight, for the generally below-normal child

(Excellent, too, for stimulating appetites of the elderly patient!) Dosage: 0.5 to 1 cc. (10-20 drops) daily. Each cc. (20 drops) contains:

l-Lysine	300 mg.
Vitamin B_{12}	25 mcgm.
Thiamine (B_1)	10 mg.
Pyridoxine (B_6)	5 mg.

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*REG. U. S. PAT. OFF.

"Patients without primary renal disease, but with albuminuria and high nonprotein nitrogen due to congestive circulatory changes, can be adequately and safely treated with Neohydrin for long periods of time."*

*Griffith, G. C.; Dimitroff, S. P., and Thorner, M. C.: Ann. Int. Med. 45:7, 1956.

07656

SECLUSION MATERNITY



FAIRMOUNT HOSPITAL
FOR UNMARRIED GIRLS
Est. 1909

Private sanitarium with certified obstetrician in charge. Folder fully describing services FREE on request. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

Write for Information
HELEN AMOS
4911 East 27th St.
Kansas City, Mo.
Phone: WA. 3-3577

Offices to be put in condition for rent, located 513 Main Street in Shelbyville

Suitable for two young doctors.

Reasonable Rent—Yearly Lease.

Contact: MRS. ALICE FOREE MASON
1101-15th Street N. W.
Apt. 406
Washington, D. C.

OCULISTS' PRESCRIPTIONS EXCLUSIVELY
MUTH OPTICAL COMPANY
Prescription Opticians
665 S. 4th Brown Hotel Building Louisville 2

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Clearview
On The Kratzville Road
EVANSVILLE, IND.

TELEPHONE 5-6181

A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.

SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery
ELECTROENCEPHALOGRAPH — CLINICAL LABORATORY—EKG AND BMR EQUIPMENT—STEREOSCOPIC X-RAY — HYDROTHERAPY.

ALBERT J. CREVELLO, M.D.
Diplomate, American Board of Psychiatry & Neurology, Inc.
MEDICAL DIRECTOR

specific against

coccic infections

Specific—because you can actually pinpoint th therapy for coccic infections. That's because most bacterial respiratory infections are caus by staph-, strep-and pneumococci. And these are the very organisms most sensitive to ERYTHROCIN—even when in many cases they resist other antibiotics.

filmtab®

Erythrocin®

(Erythromycin, Abbott)
STEARATE

with little risk of

serious side effects

Low toxicity—because ERYTHROCIN rarely alte intestinal flora. Thus, your patients seldom get gastroenteral side effects. Or loss of vitan synthesis in the intestine. Virtually, no allergi reactions, either. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), bottles of 25 and 100. Abbott

filmtab®

Erythrocin®

(Erythromycin, Abbott)
STEARATE

® Filmtab—film-sealed tablets; pat. applied for

609216

Erythromycin in the treatment of osteomyelitis

8/3/55

CASE SUMMARY

On 6/2/55, patient, male, age 28, fell on an old fracture and refractured the middle third of the right femur, superimposed on an old osteomyelitis.

On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

On 8/3, the cast was removed and leg recast. Wound was in good condition with minimal drainage.

Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

Result: erythromycin aided healing of the old osteomyelitis and kept the infection under control.

* *Communication to Abbott Laboratories*



Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

C I B A
Summit, N. J.

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

2/2228M

CROCKER-FELS COMPANY
SERVING PHYSICIANS AND HOSPITALS SINCE 1882



If you're looking for an unusually attractive examining room suite, unusually serviceable equipment, and special features to make your work easier—you'll find them in Hamilton's Steeltone, shown above. And it's available in an array of decorators' colors: white deluxe, cream white, jade green, washington blue, coral, and silver metallic.

The name Hamilton is synonymous with quality.

The Crocker-Fels Company

624 S. THIRD ST. CLay 8855 LOUISVILLE, KY.

Ask about our liberal financing plan



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Member of the American Hospital Association and National Association of Private Psychiatric Hospitals

Four modern buildings, separate for men and women Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD,
Hospital Administrator

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M.D., Neuropsychiatrist
Medical Director

T. J. SMITH, M.D., Associate

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465
334 W. BROADWAY
LOUISVILLE, KENTUCKY

WAbash 6725

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**

( ) **Centralized Bookkeeping**
(Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**

RADIUM

(Including Radium Applicators)

For All Medical Purposes

Est. 1919

Quincy X-Ray & Radium Laboratories

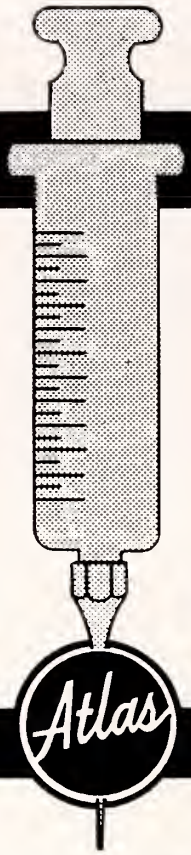
(Owned and Directed by a Physician-Radiologist)

HAROLD SWANBERG, B.S., M.D., Director

W. C. U. Bldg. **Quincy, Illinois**

PLEASE NOTICE

Advertising space in The Journal of the Kentucky State Medical Association is worth just what you make it. All advertisements appearing in The Journal have been carefully screened in order that our readers may depend on them. When you buy from firms advertising in The Journal you protect yourself against questionable products and you increase the value of this, your own Journal, to its advertisers. Remember this, and use these pages as your buying guide.



KNOWN and RESPECTED FOR A DECADE...

ATLAS INJECTABLES

Every ATLAS injectable is manufactured in our own new, ultra-modern laboratory under strictest controls. Continued research and testing assures the finest standard injectables as well as distinctive new formulae as they are perfected... Potencies and purity guaranteed, yet a realistic pricing policy makes them readily usable in every case.

Here is our latest Specialty...

RESERPINE **2.5 mg./cc. in 2 cc. Ampules pkgd. 10 ampules per box**

Order today from our representative or direct from our manufacturing laboratories. Complete medical information sent upon request.

ATLAS PHARMACEUTICAL LABORATORIES

13211 Conant Avenue **Detroit, Michigan**

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

Available

- Tax Returns
- Bookkeeping
- Delinquent Accounts (No Commission)
- Office Routines
- Office Planning
- Instructing Personnel
- Fees
- Partnerships
- Hospitals
- Clinics
- Counselling - Investments Insurance

PROFESSIONAL BUSINESS MANAGEMENT

ASSOCIATES:

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hubert G. Stiffler
Daniel L. Zeiser
Richard J. Conklin

FOR DOCTORS ONLY

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945
WOodburn 1-1010
141 West McMillan Street
Cincinnati 19, Ohio

I would like to talk with one of your Kentucky representatives.

Name .....

Address .....

..... Telephone .....

All Services Completely Confidential

KNOX Protein Previews



New Study Shows Gelatine
Restores Brittle Fingernails to Normal

Directions for making the Knox Gelatine drink in every package



Brittle, fragile or laminating fingernails are the bane of many a woman's existence. Yet this highly prevalent and distressing condition often has gone uncontrolled for lack of effective therapy. Now, you can promise these patients substantial relief in a large percentage of cases.

In a recent study[1] that confirmed previous work[2] Knox Gelatine was used to treat 36 women with fragile, brittle, laminating fingernails. The response was most gratifying. Except for three patients who discontinued the therapy, three diabetics, and two women who had congenital deformities, the splitting ceased and all other patients were able to manicure their nails to a full point by the time the study ended.

Optimal dosage proved to be one envelope (7 grams) of Knox Gelatine administered daily for three months. Efficacy has not been established with lesser dosage. If you would like more complete details of this work, just use the coupon.

1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Dept. SJ-19
Johnstown, N. Y.

Please send me a reprint of the article by Rosenberg and Oster with illustrated color brochure.

YOUR NAME AND ADDRESS

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS—1956-57

Richard R. Slucher, 2202 Seiger Villa, Louisville ..... President
Edward B. Mersch, 92 Arcadia, Covington ..... President-elect
Gant Gaither, 109½ East 7th Street, Hopkinsville ..... Immediate Past President
Karl D. Winter, 908 Heyburn Building, Louisville ..... Vice-President (Central)
Carl Norfleet, Somerset ..... Vice-President (Eastern)
Charles R. Yancey, 1110 South Main St., Hopkinsville ..... Vice-President (Western)
Woodford B. Troutman, 1616 Heyburn Building, Louisville ..... Secretary
Woodford B. Troutman, 1616 Heyburn Building, Louisville ..... Treasurer
Clyde C. Sparks, Mayo Arcade Building, Ashland ..... Speaker—House of Delegates
George W. Pedigo, Jr., 810 Heyburn Bldg., Louisville ..... Vice-Speaker—House of Delegates
Hugh Mahaffey, Richmond ..... Chairman of the Council
L. O. Toomey, 544 East Main Street, Bowling Green ..... Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan	1958
Robert C. Long, Heyburn Building, Louisville (Alternate)	1958
W. Vinson Pierce, 33 East Seventh St., Covington	1957
Leon Higdon, 333 Broadway, Paducah (Alternate)	1957

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Bldg., Paducah	1959
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1958
Third District	Ralph D. Lynn, Elkton	1959
Fourth District	W. Keith Crume, Bardstown	1959
Fifth District	Carlisle Morse, 3612 Lexington Rd., Louisville	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1958
Eighth District	Norman Adair, 630 Scott Street, Covington	1957
Ninth District	J. M. Stevenson, Brooksville	1958
Tenth District	J. Farra Van Meter, 183 N. Upper St., Lexington	1958
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1959
Thirteenth District	Charles B. Johnson, Russell	1958
Fourteenth District	Charles C. Rutledge, Hazard	1959
Fifteenth District	Charles B. Stacy, Pineville	1957

BUYERS GUIDE

JOURNAL OF THE KENTUCKY STATE MEDICAL ASSOCIATION, OCTOBER, 1956

Abbott Laboratories 904, 905
Atlas Pharmaceutical Laboratories 908
Ayerst Laboratories 899
Broyton Pharmaceutical Co. 914
Brown & Williamson Tobacco Co. 848
Burroughs Welcome & Co. 839, 886, 887
Chicago Medical Society 885
Ciba Pharmaceutical Co. 906
City View Sanitarium 898
Cleorview Sanitarium 903
The Coca-Cola Co. 889
Corn Products Sales Co. 833
Crocker Fels Company 906
Fairmount Hospital 903
Foot-So-Port Shoe Co. 899
Geigy Pharmoceuticol Co. 847
General Electric Co. X-Ray Dept. 890
The Keeley Institute 903
Knox Gelotine Co. 909
Wm. T. Greene, (Want Ad) 901
Lakeside Laboratories 841, 885, 903
Lederle Laboratories 843, 872, 873, 902
Eli Lilly & Co. 854
W. R. Long Insurance Co. 842
Louisville Med. Dental Business Bureau 907
Mrs. Alice Foree Mason (Rent Ad) 903
Medical Protective Company 899
Merck, Sharp & Dohne 891, 896, 897
Muth Optical Company 903
New Castle Sanitorium 901
N. Y. Polyclinic Med. Sch. & Hosp. 898
Parke, Davis & Co. 830, 831, 850, 851
Pfizer Laboratories 900, 912, 913
Physicians Casualty Ins. Co. 901
Pleasant Grove Hosp. 907
Quincy X-Ray & Radium Labs. 907
Riker Laboratories 849
Schering Corporation 844, 845, 852, 853, 894, 895
Clayton L. Scroggins & Associates 908
G. D. Searle & Co. 883
Smith, Kline & French 916
Southern Optical Co. 888
E. R. Squibb & Co. 892
Upjohn Company 834
Want Ad (Gen. Practitioner or Internist) 901
Wallace Laboratories 838
Wayside Hospital 898
Winthrop Laboratories 835, 884
Wyeth, Incorporated 837, 893, 911, 915

to quiet the cough

and calm the patient



INTEGRATED ACTION

1. Topical anesthetic action
   more powerful than that of cocaine
2. Antihistaminic action
   to help control cough, bronchial spasm, and allergy-caused congestion
3. Sedative action
   to allay nervous irritability
4. Expectorant action
   to render the cough productive by aiding the secretion of protective mucus

PHENERGAN®

Wyeth®
Philadelphia 1, Pa.

EXPECTORANT

Promethazine Expectorant with Codeine; Plain (without Codeine)

NEW

A

ATARAXOID is a unique, new combination of STERANE and ATARAX, which now permits simultaneous symptomatic control and reduction of attendant anxiety and apprehension in rheumatoid arthritis and other indications.

The added tranquilizer control, desirably easing mental stress, also directly assists clinical progress. It minimizes the chance of exacerbation related to emotional strain and facilitates patient confidence and cooperation in the therapeutic program toward maximum rehabilitation.

ATARAXOID exerts the anti-rheumatic, anti-inflammatory activity of STERANE distinctly superior to previous steroids, effective in radically reduced dosage, and with minimal disturbance of electrolyte and fluid metabolism.

The ataractic effect is a central neuro-relaxing action – the result of a marked cerebral specificity – free of mental fogging and devoid of any major complications: no liver, blood or brain damage. This peace-of-mind component is also used in the lowest dosage range.

Supplied: Each green, scored, ATARAXOID oral tablet contains 5 mg. prednisolone (STERANE) and 10 mg. hydroxyzine hydrochloride (ATARAX). Bottles of 30 and 100.



PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

the first and only ataraxic-corticoid

araxoid*

prednisolone and hydroxyzine

Pfizer

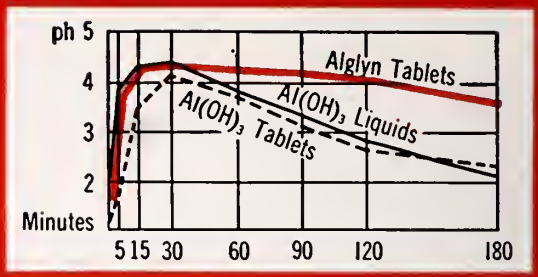
combining the newest, safest tranquilizer, ATARAX® + the newest, most effective steroid, STERANE® (prednisolone)

simultaneously controls the symptoms and the apprehension

In Rheumatoid Arthritis, other collagen diseases, bronchial asthma and inflammatory dermatoses

*Trademark

Announcing Revision of N.N.R. Monograph for



ALGLYN®

dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent in vivo studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayten PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

. . . part of *every illness*

ANXIETY

is part of

PEPTIC ULCER

Equanil®

MEPROBAMATE

(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)
Licensed under U.S. Pat. No. 2,724,720



". . . functional nervousness, including fatigue and anxiety, was by far the greatest detectable cause of recurrences of peptic ulcer symptoms, and in many instances it seemed likely that the same etiological factors were initially responsible for the ulcer."[1]

Peptic ulcer is a combination of the emotional and the physical. For total management, a combination of measures is often indicated. EQUANIL adds to the adequacy of routine treatment by countering psychic stress as a stimulant to vagal activity. It combats the anxiety and tension, and encourages restful sleep.[2]

In every patient . . . a valuable adjunct to the customary therapy

Supplied: Tablets, 400 mg., bottles of 50.
Usual Dose: 1 tablet, t.i.d.

1. Weiss, E., and English, O.S.: Psychosomatic Medicine. W. B. Saunders Co., Philadelphia, 1949, p. 358.
2. Lemere, F.: Northwest Med. *54*:1098 (Oct.) 1955.

anti-anxiety factor with muscle-relaxing action

Wyeth®
Philadelphia 1, Pa.



'Thorazine' relieved this patient's anxiety, tension and fear and made it possible for him to return to work.

'THORAZINE' CASE REPORT

patient: Anxiety, tension, and a fear of going out alone made it impossible for this 36-year-old man to work. After other treatments had failed he was given 'Thorazine'.

response: "On 'Thorazine' medication, 100 mg. orally, daily, his anxiety and apprehension disappeared rapidly. The patient was able to go out alone and to work once again. His mood was actually gay and his co-workers were surprised at this change. He was now free from care whereas before he had been distressed by the slightest difficulty."

This case report is from the files of a general practitioner.

THORAZINE*

Available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

Smith, Kline & French Laboratories, Philadelphia

'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION

COLLEGE OF PHYSICIANS
LIBRARY
NOV 21 1956
OF PHILADELPHIA

In this issue:

"Neck Dissection"

"Esophageal Hiatus Hernia"

"Wedge Amputation for Gunshot Wounds"

VOLUME 54 • NUMBER 11 • NOVEMBER 1956

you can count on cooperation when you s

When you prescribe SUSPENSION CHLOROMYCETIN PALMITATE for sick youngsters, no tears or tantrums at medicine time threaten your dosage schedule. Children readily accept this tempting, custard-flavored preparation of CHLOROMYCETIN (chloramphenicol, Parke-Davis). Succeeding doses are taken as readily as the first, because SUSPENSION CHLOROMYCETIN PALMITATE is easy to swallow and leaves no unpleasant aftertaste.

To simplify therapy still further, SUSPENSION CHLOROMYCETIN PALMITATE does not require refrigeration and may be kept conveniently in the sickroom. Its liquid form enables flexibility of dosage easily.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.



Suspension

Chloromycetin®
Palmitate

pleasant-tasting Chloromycetin for pediatric use

Supplied: SUSPENSION CHLOROMYCETIN PALMITATE, containing the equivalent of 125 mg. of CHLOROMYCETIN per 4 cc., is available in 60-cc. vials.



MEDICAMENTA VERA · PD CO

PARKE, DAVIS & COMPANY DETROIT 32, MICHIGAN

50030

The JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

EDITOR: GUY AUD, M.D.
MANAGING EDITOR: J. P. SANFORD
SCIENTIFIC EDITOR: J. L. CHUMLEY, M. D.
CASE DISCUSSIONS EDITOR: J. C. BELL, M. D.
MED. EDITORIAL EDITOR: S. A. OVERSTREET, M. D.
BOOK REVIEW EDITOR: WALTER S. COE, M. D.
ORGANIZATION EDITOR: GAIL M. RANSDELL
PRINTERS: GIBBS-INMAN, LOUISVILLE

ADVISORY COMMITTEE TO THE EDITOR

James E. Hix, M.D. — Richard J. Rust, M.D., Chairman — Francis Massie, M.D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1959	Term Expires July 1, 1958	Term Expires July 1, 1957
Robert E. Buten, M.D.	Harry D. Abell, M.D.	Carey C. Barrett, M.D.
Thomas Crume, Jr., M.D.	Henry B. Asman, M.D.	Joe Bush, M.D.
German P. Dillon, Jr., M.D.	Marion F. Beard, M.D.	Allen E. Grimes, M.D.
Pat Imes, M.D.	Rankin Blount, M.D.	Richard F. Grise, M.D.
Stanley Parks, M.D.	Glenn Bryant, M.D.	Billy Keller, M.D.
William Roland, M.D.	William C. Buschemeyer, M.D.	A. J. Miller, M.D.
Maurice Walsh, M.D.	Richard Elliott, M.D.	Robert Reeves, M.D.
James Ward, M.D.	Douglas Scott, M.D.	Charles R. Yancey, M.D.

Published at 620 S. Third Street, Louisville 2, Kentucky

Subscription $8.00 per year — Single Copy .80

Contents

SCIENTIFIC ARTICLES

NECK DISSECTION, Condict Moore, M.D. 947

ESOPHAGEAL HIATUS HERNIA, W. Burford Davis, M.D., John S. Harter, M.D., J. Ray Bryant, M.D., W. Fielding Rubel, M.D. 954

WEDGE AMPUTATION FOR GUNSHOT WOUNDS OF THE METATARSUS AND METACARPUS, Robert W. Augustine, M.D., and Merle Mahr, M.D. 959

ANXIETY, H. Burl Mack, M.D. 963

CASE DISCUSSION 967

EDITORIALS

AUTOMOBILE SAFETY 970

EXCISION OF THE RECTUM: TWO TEAM TECHNIC 970

ORGANIZATION SECTION

Surgeon is Named President-Elect 972
Health Unit Plans National Meet 972
Drs. Mahaffey, Toomey Head Council 972
House Chooses Award Winners 973
McGrath Addresses Luncheon 976
Dr. Sparks is House Speaker 976
Council Elects Dr. Aud Editor 976
Indigent Needs are Studied 974
House Acts on Medicare 974
Specialty Groups Convene 979
House Has Active Sessions 979
President Chooses Committees 981

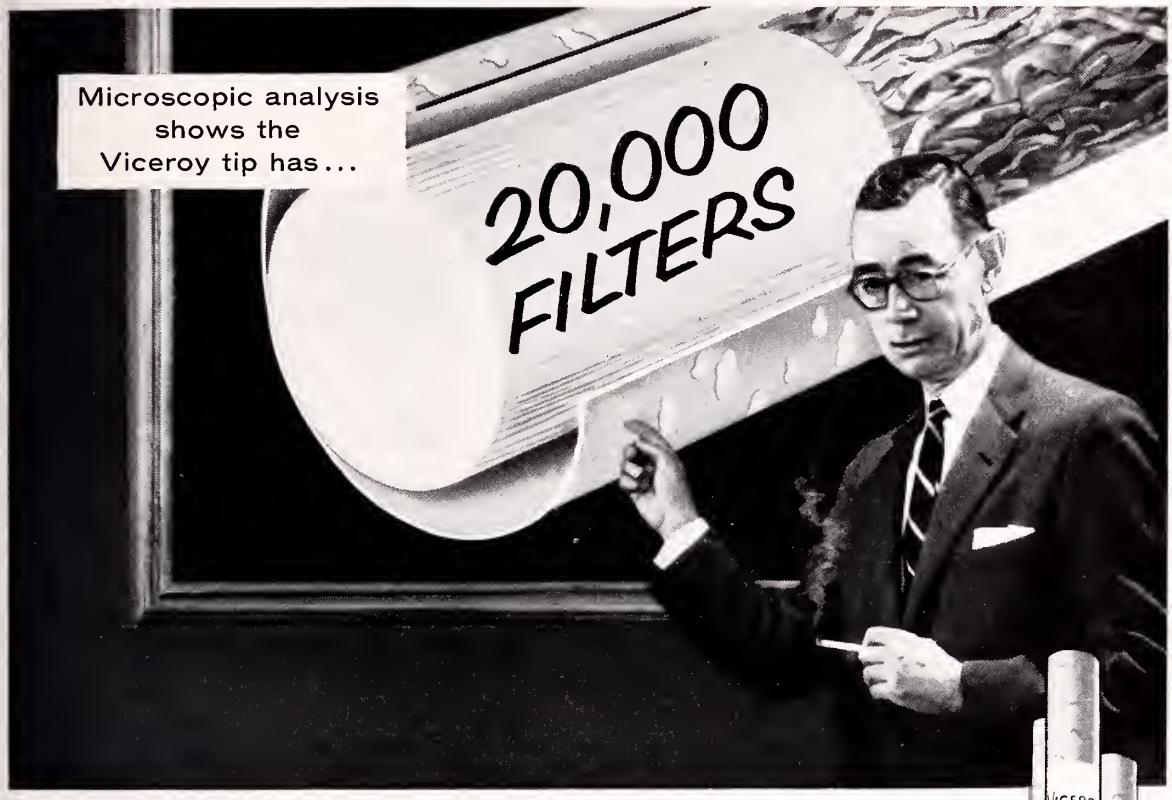
REGULAR DEPARTMENTS

President's Page 924
News Items 989
In the Books 928
In Memoriam 992
Washington News Digest 940
County Society Reports 990

Second Class Mail privileges authorized at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

HERE'S WHY SO MANY DOCTORS NOW SMOKE AND RECOMMEND

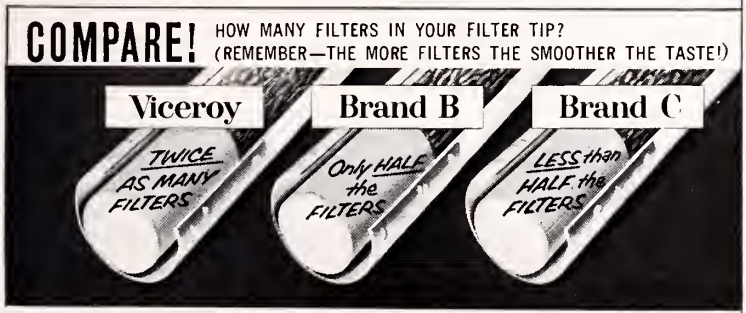
VICEROY



Twice as Many Filters

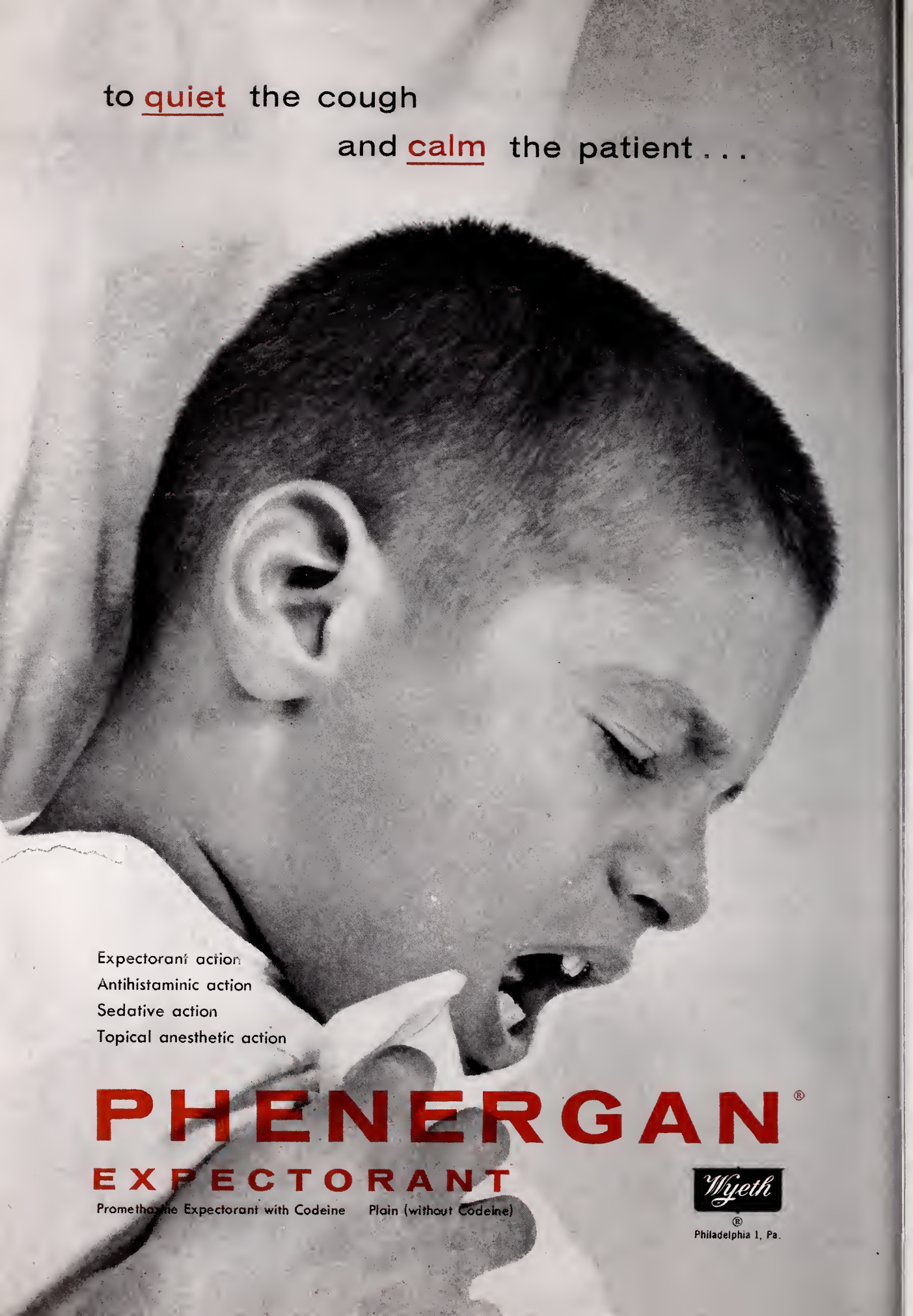
AS THE OTHER TWO LARGEST-SELLING FILTER BRANDS

For the Smoothest Taste in Smoking!



VICEROY'S EXCLUSIVE FILTER IS MADE FROM PURE CELLULOSE—SOFT, SNOW-WHITE, NATURAL!




to quiet the cough
and calm the patient . . .
Expectorant action
Antihistaminic action
Sedative action
Topical anesthetic action
PHENERGAN®
EXPECTORANT
Promethazine Expectorant with Codeine
Plain (without Codeine)
Wyeth®
Philadelphia 1, Pa.



KARO® SYRUP . . . meets the need for a highly potent source of infant carbohydrate

The need for carbohydrate, particularly during the rapid growth period of early infancy, is well recognized. One highly effective means of assuring adequate carbohydrate is by the addition of Karo syrup to the milk formula.

Karo—a balanced mixture of dextrins, maltose and dextrose—enables the feeding of larger amounts of total carbohydrate than is possible with a single sugar such as lactose or sucrose. Karo is double rich in calories and, more importantly, it is easily digested, completely utilized and well-tolerated; even by prematures and newborns.

From the standpoint of the physician, Karo permits easy adjustment of formula and safe transition from liquid to solid food. Mothers appreciate the ease of making formulas with Karo, plus its ready availability and economy. Light or dark Karo syrup may be used interchangeably since each yields 120 calories per ounce (2 tablespoons).



1906 • 50th ANNIVERSARY • 1956
CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N. Y.



message from the President

Physicians not only think about November as the month for electing important national, state and county officers, but they also must give careful attention to elections in their own county medical societies in December.

The importance of developing and maintaining a strong, active local medical society in each county can not be overstressed. It is at the county level, where the physician deals with the day-to-day problems, that medical policy should begin.

You can, therefore, render no more important service to your patients, your profession, and yourself than to contribute to a strong county medical organization. So let me urge you to do the following:

1. Hold annual election of officers in December.

2. Seek to get the best leadership possible.

3. Follow the House of Delegates mandate of a few years ago and get a good county society secretary, and keep him in office at least three years.

4. Report new officers and delegates promptly to the Headquarters office. Necessary forms will be sent to all county societies late in November.

Good, well-organized county societies make a strong state association.

R. R. Slucher

Richard R. Slucher, M.D.

24-hour control

for the majority of diabetics



GLOBIN INSULIN

'B.W. & CO.'®

a clear solution . . . easy to measure accurately

Discovered by Reiner, Searle, and Lang
in The Wellcome Research Laboratories

BURROUGHS WELLCOME & CO. (U. S. A.) INC. • Tuckahoe 7, New York

highly successful .

- faster relief of pain, photophobia
- better control of inflammation, edema, allergy
- effective against common eye pathogens
- extremely well tolerated

now available

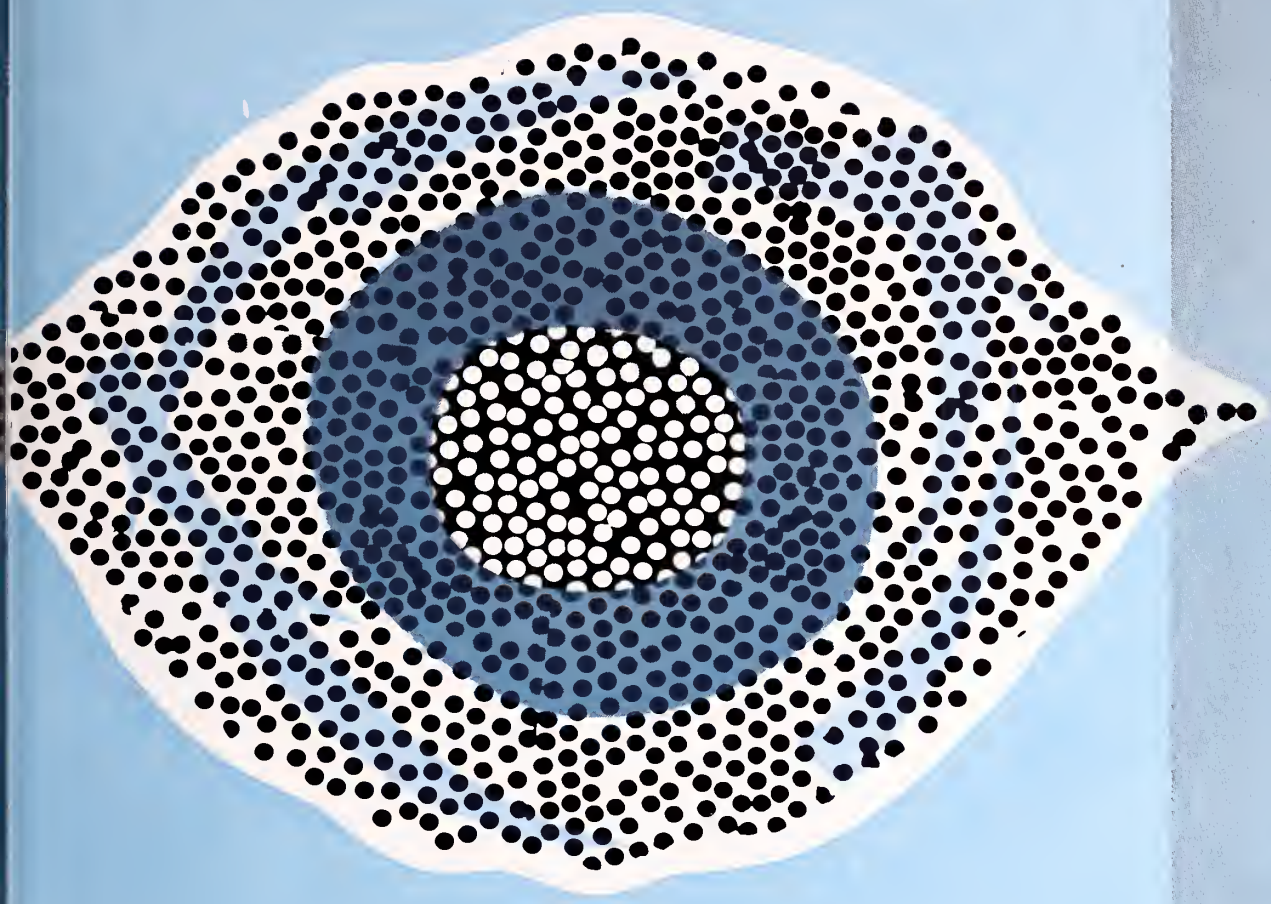
for inflammatory, allergic, infectious or traumatic eye conditions amenable to topical therapy—rapid, potent, topical Meti-steroid and anti-infective action

supplied: METIMYD Ophthalmic Suspension-*Sterile*: prednisolone acetate (METICORTELONE Acetate) 5 mg. per cc. (0.5%) suspended in an isotonic buffered and preserved solution of sulfacetamide sodium 100 mg. per cc. (10%), 5 cc. dropper bottle. METIMYD Ointment with Neomycin: each gram contains 5 mg. prednisolone acetate (METICORTELONE Acetate), 100 mg. sulfacetamide sodium and 2.5 mg. neomycin sulfate (equivalent to 1.75 mg. neomycin base); ⅛ oz. tube, boxes of 1 and 12.

METIMYD,* brand of prednisolone acetate and sulfacetamide sodium.
METICORTELONE,® brand of prednisolone.
*T.M.

MM-J-616

. in topical eye therapy



new

METIMYD

(prednisolone acetate and sulfacetamide sodium)

Ophthalmic Suspension-Sterile

and

METIMYD

(prednisolone acetate and sulfacetamide sodium with neomycin sulfate)

Ointment with Neomycin

antibacterial • antiallergic • anti-inflammatory

Schering



IN THE BOOKS



CURRENT THERAPY, 1956: by Howard F. Conn, M.D., published by W. B. Saunders Co.—632 pages. Publication date: February 7, 1956. Price $11.00.

This is the eighth edition of an annual series of books presented for the use of the practicing physician.

Proven and well accepted older methods of treatment are offered, as well as the newest and latest types. Author rotation brings news ideas, methods, and opinions. Recognized authorities may present different views on therapy, but more than one method is offered in many instances for a specific disease.

In most of the disease conditions considered there is a very brief statement made outlining necessary general thoughts on diagnosis or classification, then therapy for each item is given. The emphasis is on brevity, clarity, and specificity.

This volume is as up-to-date as any yearly publication can be. It will be of value to the intern and resident or the beginner in general practice as a ready reference book on therapy.

It is not intended to replace current magazines, and is certainly "dead" material if each successive edition is purchased. Its value is questionable if the practitioner keeps an up-to-date loose leaf compendium on therapy on his shelves, but it will probably be picked up at least occasionally from the shelf of the medical school library.

H. Burl Mack, M.D.

COMMUNITY PROGRAMS FOR MENTAL HEALTH: Theory, Practice, Evaluation; Ruth Kotinsky and Helen L. Witmer. 362 pages; $5.00. Published for The Commonwealth Fund by Harvard University Press, Cambridge, 1955.

This study by several contributors endeavors to show the status of efforts to "maintain mental health at an optimum level on a community-wide basis" as of and including the spring of 1951. The "mutual concerns" of the Community Services Committee, National Institute of Mental Health and the Mid-century White House Conference on Children and Youth were instrumental in bringing these investigations forth. By dividing the various studies into their rather large categories they lend themselves to a division of three parts, into which the book itself is divided. Namely: Theory, Practice and Evaluation.

The Introduction brings out the wide scope of various ideas and investigators of this field and points up how much education and mental health tend to lie in the same framework of thought and effort.

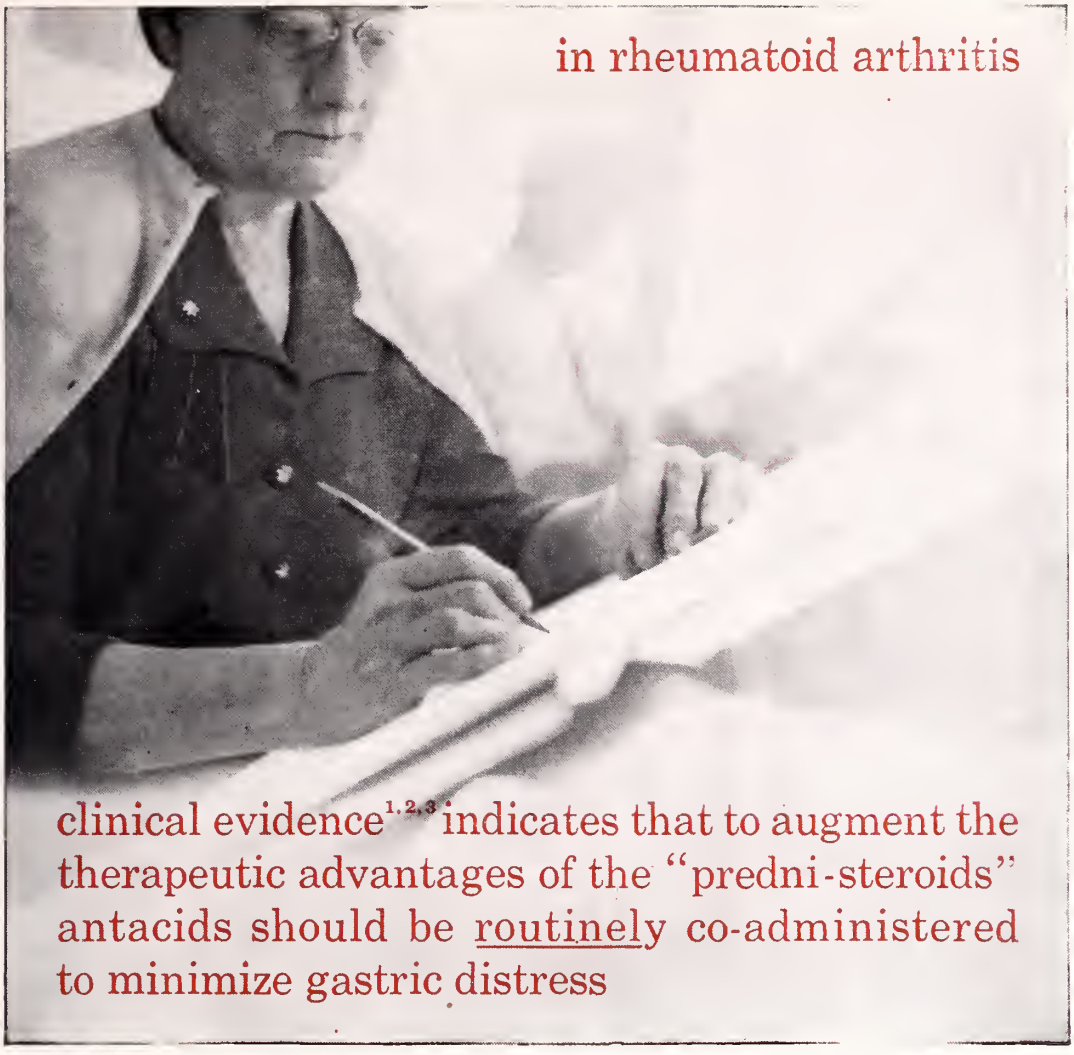
The Appendix deals with the technical details of sample surveys and gives the author's value of them.

Some of the historical features, beginning with Clifford Beers in 1908 and the National Committee for Mental Hygiene in 1909, are covered in the beginning of Part I. It is shown how the shift was made from the care of the mentally ill to preventive measures. Early the social goals and cultural values were stressed by use of "pity" and appeal to "moral values." Sol W. Ginsburg, M.D., questions the facts that have been advanced as such. He asks, "Is mental health synonymous with happiness, etc.?" In this respect he advances ideas of various mental hygienists, psychiatrists and related authors. He also adeptly points out the lack of positive factors known today in regard to the whole field of mental health and prevention. It is pointed out that treatment is grealy improved but that there is no evidence that prevention has made any mark. It would appear that in the field of mental hygiene the therapeutic psychiatrists have no real knowledge of education of the masses, nor does the educator have the background to use the psychiatric theory or be aware of their implications. The authors tend to show that research is needed to show the actual result of influence of social conditions on development and functioning.

The first part, Theory, was written entirely by one author, Sol W. Ginsburg. The second part, Practice, was written by three authors, Edith M. Tufts, H. E. Chamberlain and Elizabeth deSchweinitz. The first author takes up the features of mental health promotion and indicates how poorly defined the limits are and how many and varied the classifications that are utilized to indicate their points of interest. She asks some questions that are very pertinent, such as what are the best approaches to mental hygiene? What is the method of prevention in mental health in any program? Again it is quite evident that there is no clearly defined area from which one could approach this problem, but more a matter of trying to find the way to go. The next two authors take up nine programs in the promotion of mental health which give a brief insight into these areas. They take up the problems encountered and the estimated results of these programs. A program of mass education seemed of value in one of these. Surprising resistances were noted in some areas. For instance, the business man showed a great deal of resistance at first to the promotion of a mental health program in one area. Money, as we have recognized in the past, has always been a problem. One non-psychiatrically oriented program found profit in selling "Human Relations Lesson Plans." This was a result of an article in THE WOMAN'S HOME COMPANION and this seemed to be a good advertising medium and brought in a great deal of money to help them with the promotion campaign.

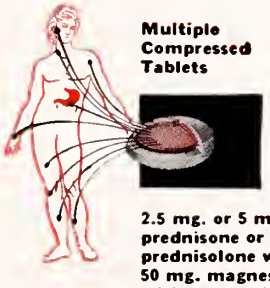
Parent education seemed to be a thought and goal of many of the programs, in fact, pros and cons of clinics vs. clinic service with community service were discussed at length and it seemed to be an impass of opinion so no conclusions could be reached. However,

(Continued on Page 933)



ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Prednisolone Buffered)



Multiple Compressed Tablets

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

'Co-Deltra'
(Prednisone Buffered)

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are trademarks of* MERCK & CO., INC.

Upjohn

Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

Cortef* *tablets*

Supplied:

5 mg. tablets in bottles of 50
10 mg. tablets in bottles of 25, 100, 500
20 mg. tablets in bottles of 25, 100, 500

*REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF HYDROCORTISONE (COMPOUND F)

The Upjohn Company, Kalamazoo, Michigan



Journal Report:

Hypertensive symptoms relieved in 96% of patients

"Comparison of pentolinium [ANSOLYSEN] with other preparations in 25 patients with severe essential hypertension, for whom all other methods of management had failed, showed that pentolinium is the most effective of available agents in reducing dangerously high blood pressure to the desired levels, and in modifying some of the complications of hypertension, as cardiac decompensation, cardiomegaly and retinopathy. . . .

"In 96 per cent (24 patients) clinical symptoms were relieved and the blood pressure maintained at comfortable levels. . . ."[1]

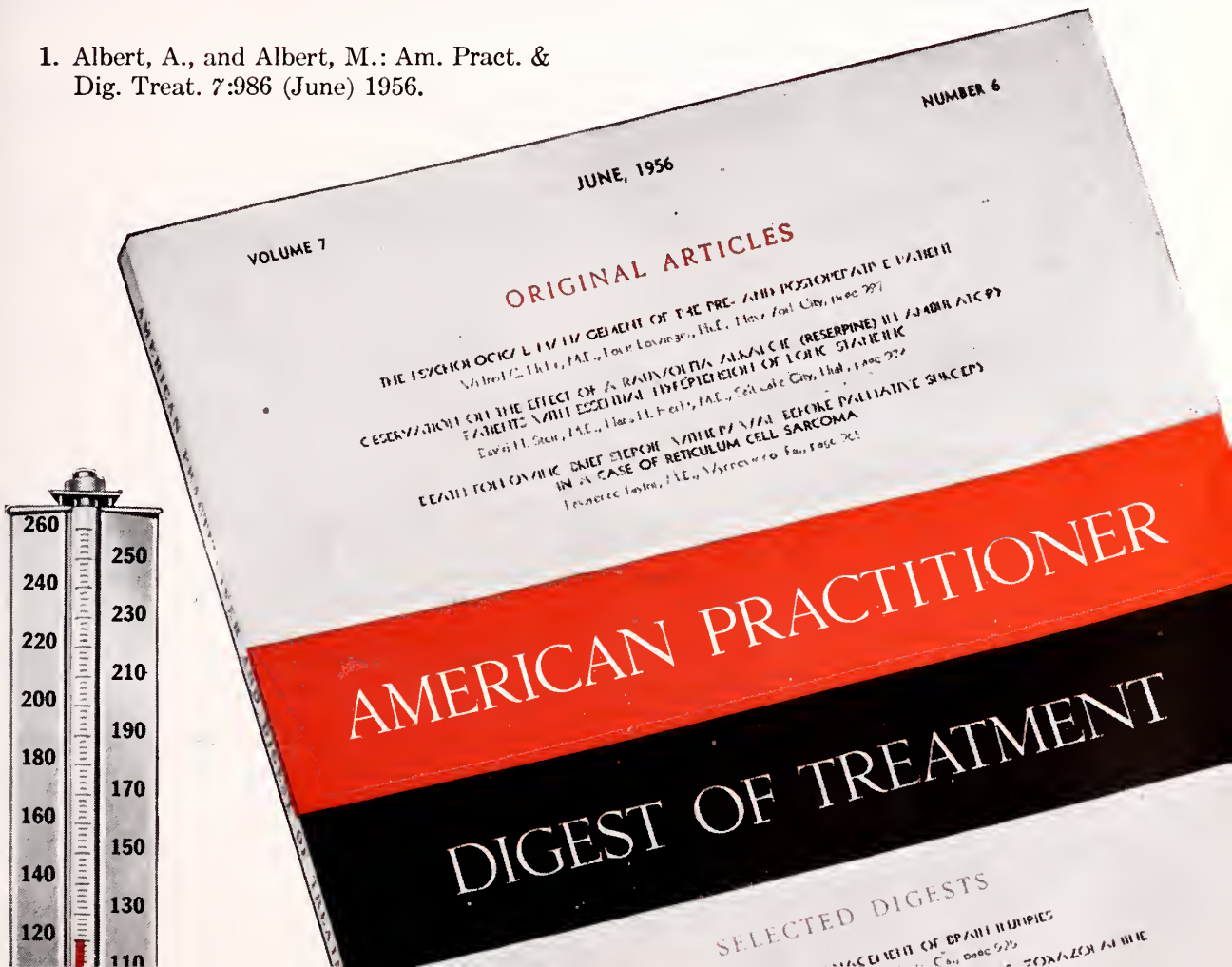
ANSOLYSEN®

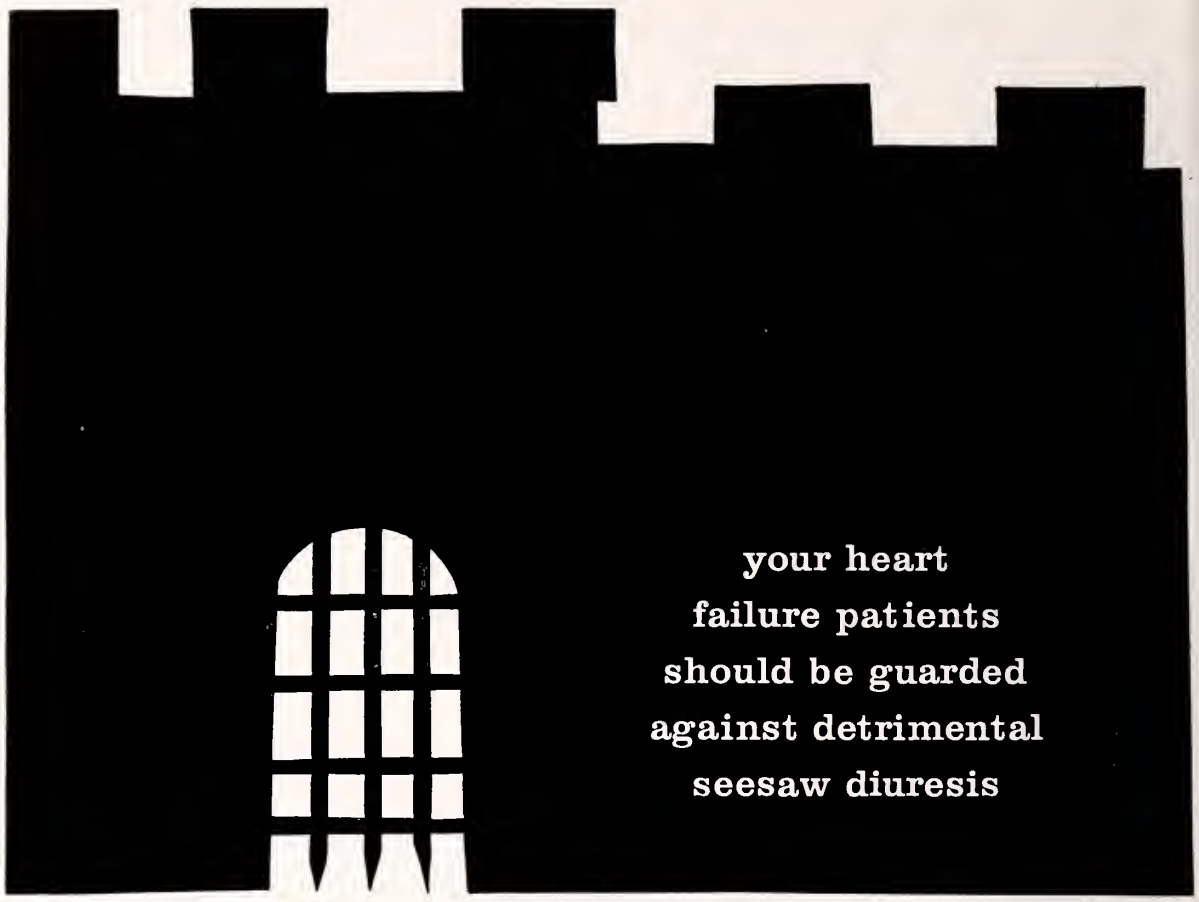
TARTRATE — Pentolinium Tartrate

Lowers Blood Pressure

Wyeth®
Philadelphia 1, Pa.

1. Albert, A., and Albert, M.: Am. Pract. & Dig. Treat. 7:986 (June) 1956.





PATIENTS IN FAILURE NEED AN ORGANOMERCURIAL

Limiting dosage to once daily to avoid refractoriness, or omitting alternate days to circumvent gastrointestinal irritation—necessary with some diuretics—results in a seesaw of diuresis with fluid reaccumulation and recurrent strain on the already failing heart.

With the organomercurials, dosage is individualized and administered as needed, to produce sustained, dependable diuresis.

TABLET

NEOHYDRIN®

BRAND OF CHLORMERODRIN (16.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure

MERCUHYDRIN® SODIUM
BRAND OF MERALLURIDE INJECTION

LAKESIDE

02556

In the Books

(Continued from Page 928)

the ideas seemed to be excellent, both for and against it.

Barbara Biber, who was the last author in Part II, had a rather large amount of material in reference to schooling as an influence in developing a healthy personality. By examining the area of school influence on personality development this writer again points up the lack of scientific evidence of what is best for mental health and what is best in regard to teaching. She also, however, gives excellent values as we know them today and some stimulating thoughts as to possible goals for the classroom. Especially important, it seemed, was the idea of classroom flexibility to foster quiet as well as noise at appropriate times. The writer examined those three school projects. The project directed toward preventing prejudice was highly charged emotionally and seemed to fall short of its purpose in helping the teacher. Another project seemed to indicate that mental health was an all pervasive phenomena that was not to be taught as a subject per se but rather as a part of every other subject. It would appear that this attitude of mental health being a part of everything that one does in life and being taught as such was accepted generally.

Part III, Evaluation, was written by two authors, Louisa P. Howe and Maria Jahoda. These authors, in reference to the evaluation of the various mental health programs, came to the conclusion that it was most difficult to assess the various programs but they tried to point out the various thoughts and bring out the difference in certain areas. The one author pointed up her own ideas as to these values which again add to the complexity of the problem. It would appear that they have made a good job in reviewing these various programs and it must have been a considerable task to do so and took considerable time and effort. A lot of the material here seems to belabor what has already been said in previous articles and this is more or less a summary of what we have already known. However, for someone who is in the field and wishes to review the attitudes on those various situations would get a lot out of this particular evaluation. The author explores the social psychology of mental health, which was, of course, probably the most difficult job and has worked out some very intriguing hypothesis and evaluation of the theories in an effort to evaluate personality. Again we have the problem of the absence of a good scientific concept of mental health, prevention and normal behavior, abnormal behavior and perception of reality, etc., that she points to in a very realistic way and shows how the effort to evaluate these various concepts cause a great deal of conflict and difficulty. She ends up this particular area by making some propositions for research.

Robert Holt wrote the article on the problems of the use of sample surveys and does a good job in evaluating this and gives some technical advice in relation to it. For someone who is interested in evaluating this situation I believe this presents a very realistic and detailed accounting of this particular problem.

It would appear that this book has quite a lot of useful information for people who are dealing with education and social work, or even those who are interested in mental health programs themselves because it brings out certain problems and difficulties and pitfalls that we have all encountered and have been wondering about for a considerable length of time. This study seems to me to be a most complete evaluation of the present problems in regard to mental health and mental hygiene programs.

Louis M. Foltz, M.D.

PULMONARY CARCINOMA: Edited by Edgar Mayer, M.D., and Herbert C. Maier, M.D., 540 pp. New York University Press. Distributed by J. B. Lippincott Co., Philadelphia.

This volume on the timely subject of pulmonary carcinoma, a rapidly increasing disease, is well edited by an outstanding internist and an excellent thoracic surgeon. The many facets of pathogenesis, diagnosis, and treatment are concisely dealt with by eighteen contributions.

This book is well illustrated, especially from the standpoint of diagnosis. Many interesting X-rays have been reproduced. Included is an excellent color photographic collection of specimens and slides.

Chapters on the biology of cancer and the environmental and occupational factors in the development of lung cancer are extremely interesting and offer real challenge and inspiration to the youthful investigator.

The management of lung cancer includes sections on surgical therapy, chemotherapy, the use of isotopes, the treatment of inoperable cases and the psychologic aspects.

In conclusion there is a completely illustrated atlas of case presentations demonstrating the pitfalls encountered in diagnosis and the lessons learned in retrospect. This should be of interest to anyone dealing with any phase of the challenging problem of pulmonary cancer.

This very readable book will certainly increase the reader's index of suspicions of early lung cancer. Mayer's and Maier's, Pulmonary Carcinoma is highly recommended for all practitioners.

W. Burford Davis, M.D.

THE MORPHOLOGY OF HUMAN BLOOD CELLS: L. W. Diggs, M.A., M.D., Dorothy Sturm, Ann Bell, B.A.; 181 pages; $12.00; W. B. Saunders Company. Publication date: May 22, 1956.

This book is the first atlas of blood cells that has appeared in some time. The improvements of recent years in color reproduction are apparent in the plates. The drawings are well done and accurate with a fairly wide and representative range of cells shown in each category.

The use of the newer terminology only, particularly in the discussion of the red cell series, may be confusing to some. To this reviewer, the use of both old and new terminology would have enhanced the value of the book, since the new terminology is not as yet universally accepted.

The book is a valuable reference in the laboratory, both for the physician himself and the technician. The short discussions of the abnormal processes are also well done and will be helpful to the practitioner.

Marion F. Beard, M.D.

Lysine plus vitamins

to help children eat more,

grow more!



INCREMIN combines the amino acid lysine with vitamins B_1, B_6 and B_{12}—essential nutrients that stimulate appetite, and promote more efficient utilization of protein. For children who are problem eaters, for the underweight, for the generally below-normal child—INCREMIN will usually produce a remarkable and prompt improvement!

Cherry flavor. Can be mixed with milk, milk formula, or other liquid. In 15 cc. polyethylene dropper bottle.

Dosage: 0.5 to 1 cc. (10-20 drops) daily. Each cc. (20 drops) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12}	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Alcohol	1%

Excellent for the elderly! INCREMIN serves equally well to stimulate lagging appetites in geriatric patients.

New

INCREMIN*

Lysine-Vitamin Drops

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.



Designed for all infant feeding from birth to the end of the first year, Baker's Modified Milk is a time-saver for busy physicians and busy hospitals. Simply dilute Baker's to prescribed strength with water.

Baker's Modified Milk is furnished gratis to all hospitals for your use.

FEEDING DIRECTIONS

(Normal dilution for liquid provides 20 calories per liquid ounce.)

	Baker's	Boiled Water
Hospitol	1 part	2 parts
First week at home	1 part	1½ parts
After first week at home	1 part	1 part

Also available in powder form. (Normal dilution one toblespoon to 2 ounces of woter provides 20 colories per fluid ounce.

*Made from Grade A Milk (U. S. Public Health Service Milk Code)

THE BAKER LABORATORIES, INC.

Milk Products Exclusively for the Medical Profession

Main Office: **Cleveland 3, Ohio** • ***Plant:*** **East Troy, Wisconsin**

Sodium Restriction

A. Indications

1. Congestive heart failure
2. Hypertension
3. Cirrhosis
4. Prefnancy edema
5. Obesity

B. Management

1. Salt Free Diet
2. Salt Substitutes

℞

Neocurtasal

New improved formula - now the best tasting. Used like table salt.

Winthrop



Neocurtasal ®
2 oz. Shakers + 8 oz. bottles

Meat...

Good Nutrition and Endocrine Functioning

Maintenance of homeostasis attuned to health devolves upon good nutrition and normal functioning of the enzyme and endocrine systems.[1,2,3] Conversely, by impairing vital activities of the endocrines, poor nutrition can seriously disturb production of hormones needed to regulate metabolic processes.

Intense and prolonged deficiency in essential nutrients and food energy depresses pituitary, gonadal, and other endocrine activity, leading to subnormal physiologic states. Clinical studies exposing male volunteer subjects to a semistarvation diet produced symptoms resembling those of various endocrine dysfunctions.[4] Since the pituitary and other hormones are protein in nature, it appears logical to assume that protein nutrition plays an important part in their synthesis.[5]

Meat, by supplying valuable amounts of high quality protein, B vitamins, essential minerals, and fat containing unsaturated fatty acids, contributes importantly to any role that good nutrition may play in the maintenance of the endocrines, their functioning, and the production of hormones.

---

1. Ralli, E. P., and Dumm, M. E.: The Hormonal Control of Metabolism, in Wohl, M. G.: Modern Nutrition in Health and Disease, Philadelphia, Lea and Febiger, 1955, pp. 57-74.
2. McHenry, E. W.: Nutrition and Endocrine Function, Borden's Review of Nutrition Research, *16*:17 (Mar.-Apr.) 1955.
3. Ershoff, B. H.: Conditioning Factors in Nutritional Disease, Physiol. Rev. *28*:107 (Jan.) 1948.
4. Keys, A.; Brozek, J.; Henschel, A.; Mickelsen, O., and Taylor, H. L.: The Biology of Human Starvation, Minneapolis, University of Minnesota Press, 1950.
5. Samuels, L. T.: Progress in Clinical Endocrinology, New York, Grune and Stratton, 1950, p. 509.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago . . . Members Throughout the United States

NEW

For Pain-Free

of everyday

In "Rheumatism"*

Multiple

TEMP

combine:

PREDNISOLONE *(1 mg.)*

+

ASPIRIN *(0.3 Gm.)*.....

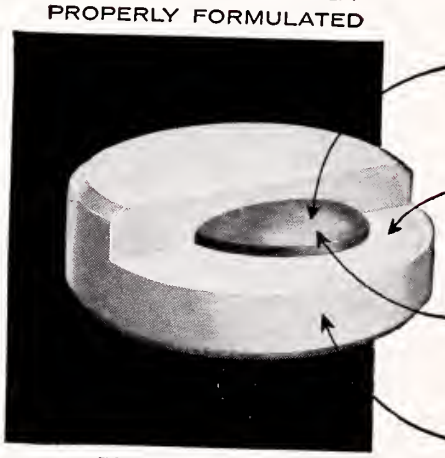
+

ASCORBIC ACID *(50 mg.)*

+

ANTACID *(0.2 Gm.)*.....

THE PROPER FORMULA
PROPERLY FORMULATED



Physical separation of the steroid component from the aluminum hydroxide as provided by the Multiple Compressed Tablet construction assures full potency and stability of prednisolone.

*Early rheumatoid arthritis
Rheumatoid spondylitis
Osteoarthritis
Still's disease
Psoriatic arthritis
Bursitis
Synovitis
Tenosynovitis
Myositis
Fibrositis
Neuritis

Performance

activities

Patients



Compressed Tablets

OGEN®

..... for anti-inflammatory, anti-rheumatic benefits *at effective low dosage.*

..... for analgesia plus additional anti-rheumatic activity.

..... for anti-stress support that guards against adrenal ascorbic acid depletion.
(Ascorbic Acid present as 60 mg. Sodium Ascorbate.)

..... dried aluminum hydroxide gel minimizes the possibility of gastric distress.

DOSAGE: *1-4 TEMPOGEN Tablets t.i.d. or q.i.d. (TEMPOGEN Forte, 1 or 2 tablets t.i.d. or q.i.d.) for one or two weeks. Then lower by 1 tablet every four or five days to maintenance level.*

SUPPLIED: *TEMPOGEN and TEMPOGEN Forte —in bottles of 100 Multiple Compressed Tablets. (TEMPOGEN Forte provides 2 mg. of prednisolone.)*

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.



WASHINGTON NEWS DIGEST



Washington, D. C.—In addition to helping states make monthly public assistance payments to certain indigent persons, the federal government for a number of years also has contributed to the cost of their medical care. Because the grants formula is somewhat complicated, and the amount of medical care varies with the states, this U. S. contribution cannot be fixed definitely. It is estimated at about 90 million dollars a year.

About a third of the states now deposit these federal grants—which must be matched 50-50—in a separate fund, from which the medical care costs are paid directly to the vendors, such as physicians, dentists, hospitals, nursing homes and druggists. The remaining two-thirds include medical care costs in monthly checks to the indigent, and the states expect these people to pay their own medical bills.

But beginning next July 1, this U. S.-state medical care arrangement is going to be drastically altered.

For one thing, the U. S. will increase its payments from the current $90 million a year to between $200 million and $300 million. For another, *all* medical care money under the new program will be put into a separate fund, from which the indigents' medical bills will be paid, in one way or another, by the state itself.

It is true that in some states the new program will not have much effect. This will be the case with those states that already have a substantial medical care program and see no reason for increasing it and with those unable to raise the matching money.

But the amount of money potentially available to each state is significant, and in most states the changeover from the old to the new systems will have an important effect on physicians and other vendors of medical care. For example, eight states will have "new" medical care funds in excess of 10 million dollars, if they put up half the money. California's potential fund is $27 million and New York's and Texas' more than $18 million each.

Before state welfare directors can start operating under the new program they will have to decide (a) whether they will require doctors to agree to a fee schedule, if one is not already in operation in their indigent care program, and (b) how the doctors will be reimbursed (whether through their societies or other mechanisms, or directly by the government). Some state welfare officials already have approached state medical societies to talk over the situation.

(U. S. contributes to indigents in only four categories—the aged, dependent children, the blind and the disabled. For their medical care, it will offer states $3 per month for each adult and $1.50 for each child, money which the state must match. It is out of these funds that payments will be made for medical care).

NOTES:

Because most applicants did not supply enough information, the council in charge of grants for medical research facilities approved only a handful of projects at its first meeting. Although $30 million was available, only $764,159 was allocated. Money went to seven institutions. However, the expectation is that the fund will be just about exhausted at the December meeting of the council, as more than 250 hospitals, schools and laboratories have asked for money.

First head of the new National Library of Medicine is the man who steered the Armed Forces Medical Library through the last seven troubled years—Col. Frank B. Rogers. He is on loan to PHS, which is in charge of the new institution to be built up around AFML.

Hearings will be held probably in December by the House Interstate and Foreign Commerce committee on federal aid to medical education. The expert panel system will be used, instead of lone witnesses. Currently the committee staff is analyzing information received in response to questionnaires sent out to about 60 organizations interested in medical education.

A six-man advisory committee, named by Secretary Folsom, is attempting to work up suggestions that will help hospitals improve care and reduce costs. Some possibilities: central cafeterias for ambulatory patients, light housekeeping work done by some patients themselves.

Regional Small Business Administration offices now are taking applications for loans to three types of health facilities—hospitals, nursing homes, and medical and dental laboratories. Institutions must be "small" and must be run for private profit.

recognized

as a potent, specific anti-arthritic

established

by over 100 million patient days

substantiated

in more than 700 published reports

BUTAZOLIDIN®

(phenylbutazone GEIGY)

potent, specific anti-arthritic

Based on an impressive background of achievement attained over a period of four years involving both long-term and short-term therapy in all the major forms of arthritis, BUTAZOLIDIN is recognized as one of the most effective anti-arthritic agents currently available.

relieves pain

improves function

resolves inflammation

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before prescribing it.

GEIGY

GEIGY PHARMACEUTICALS, Division of Geigy Chemical Corporation, New York 13, N.Y.

72556

when dandruff stands out as a sig

prescribe **SEBIZON** Lotion

for an extra therapeutic dividend

a method of choice for **rapid control** of seborrhea of the scalp and seborrheic dermatitis in children as well as adults...**no complicated shampoo or timing procedures:** patient rubs in SEBIZON any time of the day, washes out when convenient ...acts as hair dressing: **no odor, no oily or greasy residue,** no tinting of hair.

especially useful when dandruff escapes control again

antiseborrheic and anti-infective SEBIZON is a cream-type vanishing lotion containing 10% sulfacetamide sodium.

available on prescription only in 3 oz. plastic squeeze tube.



SEBIZON,® antiseborrheic preparation.

Schering

SZ-J-4106

ut not a complaint



THE KENTUCKY PHYSICIANS' PLACEMENT SERVICE

The Kentucky Physicians' Placement Service is operated by the KSMA for the purpose of assisting physicians looking for locations and communities needing physicians to get together. For more information on the listings below, write: Kentucky Physicians' Placement Service, 620 South Third Street, Louisville, Ky.

Locations Wanted

A thirty-year-old, married physician, graduate of the University of Louisville. Has completed internship and desires general practice in a community of 10,000 to 15,000. Available immediately. LW 101

A twenty-nine-year-old married physician, graduate of Northwestern University. Presently in the Armed Services. Desires general practice in community under 10,000 in population. Available June, 1957. LW 102

Thirty-three-year-old, single physician, graduate of the University of Virginia. Desires to practice general surgery. Priority IV. Available now. LW 103

A thirty-year-old, married physician, graduate of the Medical School of Virginia. Has completed military service. Desires general practice as assistant or associate. Available July, 1957. LW 104

A thirty-year-old, married physician, graduate of Vanderbilt University School of Medicine. Priority IV. Desires to practice pediatrics in a clinic or as an associate in a small community. Available now. LW 105

Twenty-eight-year-old, married physician, graduate of the University of Tennessee, School of Medicine. Presently on duty with the Air Forces. Would like to practice internal medicine or pediatrics as an associate. Phi Rho Sigma Medical Fraternity. Available February, 1957. LW 106

Twenty-nine-year-old, married physician desires general practice in a community of 5,000 to 20,000. Graduate of Emory University and now in residency. Available July, 1957. LW 107

Forty-five-year-old physicain, married, graduate of St. Louis University School of Medicine. Priority IV. Wishes to practice obstetrics and gynecology in clinic or as associate. Member of the AMA. Available now. LW 108

A twenty-eight-year-old, married physician who wishes to practice internal medicine in a community of 20,000 and over. Graduate of Duke University School of Medicine. Priority IV. Completing board qualifications for internal medicine. Available July, 1957. LW 109

A thirty-one-year-old, single physician, graduate of the University of Louisville, School of Medicine. Priority IV. Wishes to do general practice in clinic or as associate. Small community of 5,000 or over. Now in residency. Available August, 1957. LW 110

Physician Wanted

Eastern Kentucky community desires physician. Office space and housing available in modern building. Three schools, including junior college, four churches and numerous civic clubs. Population of 2,000 with a trade area of 20,000. PW 101

Excellent opportunity: Physician to do general practice as an associate. Must have two to six years experience. Population about 500,000 with eight hospitals, medical school and numerous industries. PW 102

Western Kentucky community of 1,200 desires a physician for general practice. Has a trade area of over 4,000. Office and living space available. PW 103

Central Kentucky community needs the services of a general practitioner. Prosperous community within twelve miles of hospital facilities. PW 104

Central Kentucky community of 3,500 wants a physician for general practice. Located near the Bluegrass section of Kentucky with hospital facilities available within 12 miles, with 900-bed capacity. Office and living space can be arranged. PW 105

General Practitioner needed in small community in Northern Kentucky. Very close to cities with hospital facilities. PW 106

Doctor wanted for Central Kentucky community. Every available assistance will be given him by the people of this thriving community. Office space available. PW 107

This location is in the heart of the fast growing industrial area of the Ohio Valley and need a physician for general practice. Office space available and new homes being built. Population 1200 with a trade area of approximately 9000. PW 108

Western Kentucky town needs a general practitioner. Housing and office space can be arranged. New clinic with one wing empty at present. One physician presently located in this community and would welcome assistance. PW 109

A doctor is needed in a Northern Kentucky community, 20 miles distant from 300-bed hospital facilities. PW 110



with THORAZINE*

preoperatively

"anxiety and apprehension
give way to
relaxation and calmness"[1]

When added to premedication, 'Thorazine' calms apprehensive, tense patients, facilitates induction and intubation, decreases reflex irritability, minimizes emergence excitement, and "markedly inhibits postoperative vomiting."[1]

1. Mathews, Morris and Moyer: Am. Pract. & Dig. Treat. 6:360 (Mar.) 1955.

'Thorazine' is available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

For information write:

Smith, Kline & French Laboratories
1530 Spring Garden Street, Philadelphia 1

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

fastest and shortest-acting oral barbiturate



'Seconal Sodium'

(SECOBARBITAL SODIUM, LILLY)

622011

Lilly
QUALITY / RESEARCH / INTEGRITY

The secret of sleep in a capsule

When simple insomnia is the presenting complaint, a bedtime dose of 'Seconal Sodium' is often indicated. Its effect is prompt—within fifteen to thirty minutes; relaxation and sleep follow quickly. Your patient awakens refreshed and well rested.

Available in 1/2, 3/4, and 1 1/2-grain pulvules at pharmacies everywhere.

80TH ANNIVERSARY 1876 · 1956 / ELI LILLY AND COMPANY

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 NOVEMBER, 1956 NO. 11

NECK DISSECTION

CONDICT MOORE, M.D.**
Louisville

Introduction

NECK dissection seems always to be a lively topic for discussion because of disagreement among doctors as to its indications, the structures it is necessary to sacrifice, the degree of mutilation involved and the value of the operation as a curative measure. It is invariably performed for real or suspected metastases from cancer and it is surprising to find that in all large series of neck dissection, in general surgical clinics, a single cancer, cancer of the tongue, accounts for one quarter of all patients undergoing the procedure.[16] We have felt that, since about 85 per cent of recurrences in mouth cancer take place within the first year,[12] it would be worthwhile at this time to present a preliminary review of our recent experience with this operation in an attempt to detect trends; perhaps we may find a guide to improved results in the future.

History

George Crile, Sr.[8] did the major basic work in devising the operation as it is presently performed by most surgeons. He began his study before 1900, properly emphasizing the necessity for sacrifice of the sternocleidomastoid muscle and internal jugular vein for adequate margin around cancerous nodes. This pioneer also explored the results of sacrifice of various essential neck structures, such as the vagus nerve, carotid arteries, etc. George Semken,[20] in New York City, studied and performed neck dissection tirelessly in the early years of the century, sparing the structures Crile would remove, and he inspired others to undertake his painstaking technique. Vilray Blair and J. Barrett Brown in St. Louis[3,4] were studying and performing neck dissection, alone and combined, with Crile's technique at the same time; they early advocated routine neck dissections for lip and mouth cancer. In recent years, Hayes Martin[16,17] has made significant contributions to the development of the operation, its use combined with other procedures, and has well analyzed a large series in his clinic at Memorial Hospital in New York City. His technique follows Crile's in most essentials. Throughout its history neck dissection has had the adjective "radical" linked to it by most writers: this qualification appears outmoded today when mortality from the operation is small, and modern concepts seem to warrant no qualifying word at all, or possibly only the term "adequate."

Limitation of Discussion

In any discussion of cancer treatment it seems important to limit the study to one histologic type of cancer, since the natural history, or behavior, of one type of cancer so often strikingly differs from that of other types. With this in mind, we have limited this study entirely to epidermoid or squamous carcinoma arising above the clavicle; therefore, cancer of the mouth and throat wherein neck dissection was employed will concern us mainly.

Rationale of Neck Dissection

Squamous cancer is surprisingly predictable in its behavior, compared with many other malignant growths. Especially in the face and mouth area, it spreads first via the rich neck lymphatic system. This fact is substantiated by

**From Department of Surgery, University of Louisville School of Medicine.

*Presented at the May 19, 1956 meeting of the Kentucky Surgical Society at French Lick.

the rarity of distant metastases in face and mouth cancer without local nodal involvement, and, conversely, the frequency with which local nodal metastases are demonstrated without evidence of distant metastases. The time-honored concept of cancer explains this initial predilection for lymphatic travel in this way: the cancer cell, after some time of increasing autonomy in its colony, loses its cohesiveness with its fellows and is swept along by the tissue fluids in their natural channels, the lymphatics, to end in the tissue fluid filters, the lymph nodes, where the channel becomes too narrow for easy passage. Here, the cell or small group of cells either dies, lies dormant, or grows into a metastasis. This process occurs repeatedly, probably hundreds and thousands of times, most of the cell transplants being killed or held dormant by body resistance factors, a few growing and seeding their progeny to yet other nodes. Each succeeding involved node brings the metastasizing tumor nearer the thoracic duct entrance into the blood circulation, or capillaries may be invaded directly along the way. In either case, blood-borne disease eventually occurs.

Two points bear remembering concerning the natural history of squamous cancer. One: it is the lymphatics which carry the first metastasizing cells, and there is a definite time lag before survivable cells are carried in the blood. Second, it is the lymph nodes nearest the parent cancer which appear to provide the first and richest soil for growth of metastasis. Hence, it is this time lag between lymph-borne and blood-borne metastasis in squamous cancer which gives the clinician his chance for curative treatment; patients with disease diagnosed before metastasis could occur are certainly in the minority, in mouth cancer. (The expected five-year survival without any neck treatment in tongue cancer can be estimated as 18 per cent, according to Martin's figures.)[16] It is also evident that the tissues, particularly lymphatic, immediately surrounding the cancer, those best prepared for metastasis and in any of which microscopic disease may lurk, must all be considered, with the primary, as one cancer block when treatment is planned.



Fig. 1 Outline of incision for neck dissection.

Material Studied

As a basis for discussion of neck dissection, we are presenting a strictly preliminary analysis of our experience with 43 neck dissections for squamous cancer of the mouth and face area, performed in the last three and a half years in 41 patients. These patients represent about 20 per cent of the 201 patients with cancer of the mouth and face area seen in a similar period who might have been candidates for neck dissection, many of whom were considered suitable for local treatment only or who were inoperable. There were two patients who had bilateral, nonsimultaneous neck dissections. Twenty-six neck dissections were combined with resections of the primary cancers in continuity; 17 were simple neck dissections alone. Nearly half of the procedures were performed on the surgical service of the Louisville General Hospital, much of the operating being done by resident surgeons; the remainder were done at various other Louisville hospitals. Thirty-one males and 10 females comprise the group. The primary cancer sites were: mouth — 24 (of these 15 were in the tongue), extrinsic larynx — seven, lip—six, skin—two, submaxillary gland—one, unknown—one. It is apparent that there are only eight patients in the so-called curable group of skin and lip cancer; when first seen by us, three of these were so advanced, although operable, that surgery ended in failure. The ages of the patients ran the full gamut, from 12 to 73 years, the majority of them being in the sixth and seven decades. At least 13 of the 41 patients had advanced local disease when first seen, and, in some, surgery was only justified as palliation.

Indications for Neck Dissection

Neck dissection was undertaken in this group following the conventionally accepted indications,[16] namely: (1) when there were proved or strongly suspected positive neck

nodes, (2) when removal of primary cancers nearby necessitated surgical invasion of the neck and precluded later clean neck dissections. Of course, in all cases the nodes were considered resectable and there was no evidence of distant metastases. A so-called prophylactic neck dissection was performed in only one instance. Of course, no cancer operation is strictly prophylactic in the sense of preventing metastasis; what is termed prophylactic neck dissection is really a dissection for the elimination of microscopic metastases and will be referred to later as "immediate" neck dissection.



Fig. 2 Skin flaps dissected back. Spinal accessory nerve, external jugular vein, sternocleidomastoid muscle and areolar tissue can be seen.

Technique

The operative technique followed in all cases has been that advocated by Martin,[16] Brown,[6] and others, and is widely practiced. Briefly, the dissection includes in one block the lymph nodes and lymph channels in the neck from mandible to clavicle, from midline to trapezius muscle. The sternocleidomastoid muscle, internal jugular vein, submaxillary salivary gland and the eleventh cranial nerve are removed in the process of dissection to achieve a solid block of tissue and adequate margin around the lymphatic bed. This removal of adjacent structures guards against spreading cancer should the nodes contain cancer just beneath their capsule or even through it. (When one enucleates a cancerous node, the only fair assumption is that one is spreading cancer.) The removal of muscle and vein gives better margin around most principal nodes than is accomplished in axillary or groin dissection.



Fig. 3 Completed dissection. Posterior belly of digastric muscle and hypoglossal nerve were sacrificed in this particular combined procedure.

Certain variations in technique were allowed to fit individual patients. In one instance, the eleventh cranial nerve was spared in a girl of 12, the nodes being clinically free of disease but dissection was indicated because of persistent cancer in the submaxillary triangle after an initial inadequate procedure. It was spared in one other case of lip cancer. The mandibular branch of the seventh nerve was generally spared, except in cases in which the submaxillary group of nodes was clinically involved. When neck dissection was combined with excision of the primary cancer in the mouth or larynx, various other structures were of necessity removed to obtain proper margin, such as the strap muscles and one lobe of the thyroid in some laryngeal cancers, portions of the digastric muscles, more parotid gland and, in several instances, the hypoglossal, vagus and sympathetic nerve trunks had to be sacrificed.

Mortality

Three hospital deaths occurred in 43 operations, a rate of seven per cent. All three had had previous neck irradiation and all happened at the General Hospital. Only one patient died after simple neck dissection; he was somewhat debilitated and had completed a course of heavy irradiation to palate and neck when operated upon. He bled post-operatively. This was controlled but he gradually declined, developed a large skin flap slough, finally had thrombosis of his internal carotid artery and died on the thirtieth post-operative day. The other two deaths were in extensive combined mouth, jaw and neck operations in debilitated patients with advanced disease.

One died on the tenth post-operative day of dried bronchial secretions plugging a major bronchus with the inevitable pulmonary complications. The other died on the fourteenth day of too much surgery for a man with a three-year history of luetic aortitis, aortic aneurysm and bouts of cardiac decompensation. He also developed an internal carotid artery thrombosis. Our single mortality in 17 simple neck dissections amounts to six per cent; Kremen reports three per cent.[1] Martin reports no mortality in 100 consecutive neck dissections in recent years, although a rate of 3.4 per cent is noted going back to pre-antibiotic days.[16] Harrold at Memorial Hospital reports a mortality of 2.7 per cent in over 300 combined procedures.[12] These figures are lower than ours.

Morbidity

There were some troublesome, but no major complications attributable to neck dissection. Pulmonary complications were not a problem. One patient developed a sucking effect in the superior mediastinum with subsequent rupture of air into one pleural space. This was suspected at the close of the operation and an immediate X-ray film showed minimal pneumothorax, but it was so slight as to require no treatment in this instance. No post-operative shock of serious proportions developed because of the availability and adequate use of blood transfusions.

Inadvertent interruption of branches of the seventh, tenth and twelfth cranial nerves was done in six patients, but there were no effects of clinical consequence.

Three wound infections and two post-operative hematomas occurred.

One cardiac patient suffered an episode of myocardial ischemia on the fifth day, but recovered.

Most simple neck dissections went home on the seventh or eighth post-operative day. Those who had combined procedures went home on the twelfth to fourteenth day.

Long-term complaints following neck dissection were of shoulder aching and stiffness of the neck. The shoulder drop and scarring are temporarily bothersome but every patient who remained free of recurrence has returned to his former job, several doing heavy labor, and these complaints usually cease after the first year. Patients and their musculatures



Fig. 4. Specimen of laryngectomy and neck dissection in continuity, showing carcinoma of pyriform sinus with single metastatic neck node. Patient living and well three years.

gradually adjust very well to the shoulder drop. One patient required excision of a neuroma in one of the cut stumps of the cervical plexus. Only one patient has regretted the surgery. She is an older woman who suffered a lower lip partial paralysis and a Horner's syndrome and developed chest metastases within the first year. Her appearance and previous intuition about her recurrence justified her regret. The cosmetic result, especially in men, is perfectly satisfactory after neck dissection. Edema of the face is usually minimal and subsides in about 10 days. Maurice Ewing[10] interviewed and examined a large group of neck dissection patients at long intervals post-operatively and found "nothing to make one hestitate ever to perform the operation." Complaints are minimal when operation is properly and carefully performed and patients closely followed.

Results

Recent follow-up in every case has been obtained, although a few were by letter. Since Harrold and others have shown that most recurrences in mouth cancer take place within the first year, and since 15 of 16 failures in our group were recurrent during the first year, we feel that a brief look at one-year results is justified and may help us detect trends.

Of 30 patients operated on one year ago or more, 16 are dead or living with disease and 14 are living and well. This is 47 per cent success, so far. Two-year results in a smaller group are practically the same. Five of the failures had local neck recurrences, all at the periphery of the dissection; eight developed local recurrences of the primary tumor and five developed distant metastases.

Table 1

NECK DISSECTION FOR SQUAMOUS CANCER

No. Pts. Seen in 3½ Yrs.	201	
No. Pts. Operated	41	(20%)
Simple Neck Dissections	17	
Combined Operations	26	
TOTAL NECK DISSECTIONS	43	
Hospital Mortality	3	(7%)
Liv. & Well (of 30 Oper. 1 Yr. + Ago)	14	(47%)
Liv. & Well (of 20 Oper. 2 Yr. + Ago)	9	(45%)

Nearly 80 per cent of the neck dissections showed positively involved nodes on pathological examination. In the one-year group, 37 per cent with positive nodes are living and well; 83 per cent with negative nodes are living and well.

The size of the largest nodes involved with cancer does not seem to influence the survival rate, per se.

However, the number of node groups containing cancer does definitely have an effect on the outcome; if no nodes are involved, as stated before, 83 per cent are living and well; if only one node group is involved, the rate becomes about 50 per cent living and well; but with two or more node groups involved, the rate drops to about 10 per cent living and well. It appears to be of the utmost importance to dissect the nodes before disease spreads out of one node group. Harrold[13] has also found a marked drop in survivals when lower neck nodes are involved.



Fig. 5 Patient two and one half years after combined tongue, jaw and neck procedure.

Delay of node dissection after treatment for the primary lesion also apparently exerts a marked influence on results in mouth cancer. In lip cancer, all dissections in the one-year group were long delayed and the results are acceptable. However, in mouth cancer, the rate of 57 per cent living and well without delay drops to 40 per cent with three months delay and to zero with five months or more delay. Obviously, this last figure of zero per cent is false due to the small series; most authors reporting their results have patients cured with delayed node dissections. But the trend in these figures seems hard to ignore.

In a small group of extrinsic laryngeal cancers it was possible initially to demonstrate metastatic neck disease in all but one. Consequently, most had simultaneous laryngectomies and neck dissections. The factor of delay in neck dissection cannot be assessed here.

It is of further interest to note the effect of the primary site of the cancer on the results. In the lip and skin cancers, about two-thirds are living and well at one year; this seems a comparatively low figure for these relatively benign locations, but several had advanced stages of disease when treated by us. (One patient had had known skin cancer for 40 years.) In mouth cancer, the result is only one-half as good, about one-third of patients being well at one year. Early results in extrinsic larynx cancer are surprisingly high, nearly two-thirds of a small group being well at one year.

The effect of prior X-ray treatment is hard to evaluate because of many factors entering into the result, such as location of ports, type of therapy, degree to which it delayed neck dissection if at all, whether given for palliation



Fig. 6 Patient two weeks after neck dissection for metastatic carcinoma of lip.

or for cure, etc. Probably the lower rate with prior X-ray treatment reflects the fact that many of these patients were treatment failures undergoing surgery as a last resort.

Discussion

This study of neck dissection related to early patient survivals obviously ignores the effect of the treatment of the primary cancers on end

results. We cannot discuss this topic here. Since the treatment of the primary cancers was so varied in this series, it seems reasonable to assume that it reflects well the practices in most parts of the country. The results as analyzed are intended only to reflect what neck dissection accomplishes when used for squamous cancer at a time when most patients have obvious metastatic cancer and when 80 per cent have histologic metastasis.

In the small lip and skin cancer group, considering the proportion of advanced cases, the early results are adequate. Delay of neck dissection until nodes are positive for cancer in these patients achieves a high percentage of satisfactory results.

In the case of extrinsic larynx cancer, neck dissection has usually been done immediately and the results are satisfactory, so far. We believe it is important to do immediate neck dissection in this type of case. True extraglottic (as opposed to endolaryngeal) cancer is usually diagnosed relatively late, has usually metastasized when diagnosed and demands simultaneous, in-continuity laryngectomy and neck dissection. This approach is not new. Bocca[5] studied 500 patients with cancer of the larynx and reports an incidence of 46 per cent to 76 per cent of neck metastases in variously located extraglottic lesions. His five-year results using laryngectomy in continuity with neck dissection when nodes are clinically negative show 65 per cent living and well. Clerf employs the same treatment plan and reports 65 per cent living and well in epiglottic cancer, 50 per cent living and well in other extrinsic lesions. Even del Regato[9] favors surgery in pyriform sinus cancers. There may be room for disagreement as to the necessity for immediate neck dissection in seemingly small extrinsic lesions, but the experience of many shows that the cancer is usually twice as large in the pathology laboratory as it appears through the laryngoscope.

In mouth cancer the results are not very good, comparatively. Results may improve with earlier diagnosis but education is painfully slow. What could be changed in the treatment plan? It seems reasonable to try the principle of immediate neck dissection in mouth cancer; it has the support of many authorities, namely, Brown,[6] Grant Ward,[22,23] Kremen,[14] Willy-Meyer,[24] MacFee,[25] and seems to have worked well in extrinsic laryngeal cancer. Reports by Lyall and Schetlin[15] and by Kremen[14] of small series of patients treated by this principle show 60 per cent to 70 per cent five-year survivals in tongue cancer. Their patients have been selected, it is true, by circumstances largely out of their control, yet the results are so good that all patients' welfare would seem best served by adhering to immediate neck dissection in mouth cancer. We propose that neck dissection be part of the treatment in mouth cancer when first diagnosed and that any exceptions be made away from this rule, such as for those patients who will not tolerate, or who refuse, operation.

The argument for delayed neck dissection in mouth cancer, as advocated by Martin,[16] Slaughter[21] and Beahrs[2] is that only one patient in five would receive possible benefit from immediate neck dissection, while four would have useless operations, based upon Martin's tongue figures. It implies that a significant number of patients can be adequately treated and cured before metastases occur, escaping neck treatment entirely, and that as great a number can be cured by delayed as by immediate neck dissection. Also, few bilateral neck dissections would have to be done.

This argument is a good one; it does, in fact, show that 30 per cent of tongue cancer patients without clinical metastases can be cured without any neck treatment. What it cannot show is that the statistics can be applied to other areas of the country, and it does not show what immediate neck dissection for mouth cancer in a large series can accomplish in comparison. There is no such comparable large series yet. As stated before, two small series suggest that results can be improved. It seems reasonable that if clinics employing delayed neck dissections improve their results in the future, it will be because of dissecting clinically negative necks in continuity with the primary cancer under the indication that the neck can be cleanly done only at that time.

The argument for immediate neck dissection is more convincing and runs as follows:

(1) Most clinics see mouth cancer at a stage when metastasis is occurring or has occurred. This seems a safe guess. Sixty to seventy per cent of all mouth cancer patients are reported to have metastases, when first diagnosed.[7, 13, 11] In our mouth cancer patients, sixty-three per cent had neck metastases. But the physician does not know which patients do

not have metastases. The incidence of clinically negative nodes proving histologically positive runs from 30 per cent to 43 per cent[18,14]; therefore, the error in clinical judgment is great.

(2) Node dissection specimens reported free of metastasis by routine pathology study can be as much as 30 per cent in error. That is, one third of negative necks may be actually histologically positive. Saphir and Amromin[19] demonstrated this in serial section studies of axillary dissections. Therefore, a negative pathology report on neck dissection does not mean the patient has not benefitted.

(3) Neck dissection done when nodes are microscopically positive is cleaner than when done for macroscopically involved nodes, and probably also often removes nodes at a time when fewer nodes are involved. Our own and Harrold's [13] studies show the great drop in success when more than one node group is involved.

(4) It would be reasonable to spare the mandibular branch of the seventh nerve in all, and the eleventh nerve in some immediate neck dissections, thus markedly reducing real or suspected disability.

(5) The performance of bilateral neck dissection in all tongue cancers is not necessary. Only five per cent of tongue cancers will show contralateral involved nodes first clinically [16]; bilateral dissection would be needed in these. In 95 per cent of cases, if the homolateral side is dissected and proves negative histologically, it is a safe guess that the other side of the neck will seldom be involved. It would seem practical to wait on the second neck dissection in many tongue lesions. However, midline floor of mouth and gum lesions will demand bilateral dissections.

(6) Results in small series of patients treated by immediate neck dissection for mouth cancer are encouraging, as stated above.

Summary and Conclusions

(1) A preliminary study of the results in a small series of neck dissections performed for squamous cancer is presented.

(2) Early results seem to indicate that (a) the prognosis worsens considerably when more than one node group is involved with cancer, (b) the prognosis in mouth cancer apparently worsens proportionately with the delay in performing neck dissection.

(3) Immediate neck dissection, as opposed to neck dissection delayed until nodes are grossly involved with cancer, seems the best rule to follow in mouth and extrinsic larynx cancer.

References

1. Barclay, T. H. C., Peltier, L. F., and Kremen, A. J. Neck Dissection in the Treatment of Cancers of the Head and Neck. ANNALS SURG. *134*: 828, 1951.

2. Beahrs, O. H. Radical Dissection of Structures of the Neck: How Radical Should It Be? JAMA, *157*: 794, 1955.

3. Blair, V. P., Brown, J. B., and Womack, N. A. Cancer In and About the Mouth. ANNALS SURG. *88*: 705, 1928.

4. Blair, V. P., and Brown, J. B. The Treatment of Cancerous or Potentially Cancerous Cervical Lymph Nodes. ANNALS SURG. *98*: 650, 1933.

5. Bocca, E. Functional Problems Connected with Bilateral Radical Neck Dissection. J. LARYNGOLOGY & OTOLOGY. *67*: 567, 1953.

6. Brown, J. B., and McDowell, F. Treatment of Metastatic Carcinoma of the Neck. TR. SOUTH. SURG. ASSOC. *55*: 254, 1944.

7. Clerf, L. H. Discussion on Head and Neck Panel, p. 462; Proc. of the Second Nat. Cancer Conf., Am. Cancer Soc. Inc., 1954.

8. Crile, George, Sr. Excision of Cancer of the Head and Neck. JAMA. *47*: 1780, 1906.

9. del Regato, J. A. Discussion on Head and Neck Panel, p. 463; Proc. of the Second Nat. Cancer Conf., Am. Cancer Soc. Inc., 1954.

10. Ewing, M. R., and Martin, H. E. Disability Following "Radical Neck Dissection." CANCER. *5*: 873, 1952.

11. Fishel, E. Surgery as Applied to Lymph Nodes of the Neck and Cancer of the Lip and Buccal Cavity. AM. J. SURG. *24*: 711, 1934.

12. Harrold, C. C. Present Day Methods of Surgical Treatment of Intra-oral Cancer. Proc. of the Second Nat. Cancer Conf., p. 444; Am. Cancer Soc. Inc., 1954.

13. Harrold, C. C. Total Experience in Treatment of Carcinoma of Floor of Mouth at Memorial Hospital for Period 1934-1949. (to be published.)

14. Kremen, A. J. Results of Surgical Treatment of Cancer of the Tongue. SURGERY. *39*: 49. 1956.

15. Lyall, D., and Schetlin, C. F. Cancer of the Tongue. ANNALS SURG. *135*: 489, 1952.

16. Martin, H., Del Valle, B., Ehrlich, H., and Cahan, W. G. Neck Dissection. CANCER. *4*: 441, 1951.

17. Martin H., and Sugarbaker, E. L. Cancer of the Floor of the Mouth. S. G. & O. *71*: 347, 1940.

18. Morrow, A. S. Cancer of the Tongue. ANNALS SURG. *105*: 418, 1937.

19. Saphir, D., and Amromin, G. D. Obscure Axillary Lymph Node Metastasis in Carcinoma of the Breast. CANCER. *1*: 238, 1948.

20. Semken, G. H. Surgery of the Neck. NELSON'S LOOSE LEAF SURGERY, Thomas Nelson & Sons, New York. *2*: 763, 1927.

21. Slaughter, D. P. Neck Dissection: Indications and Technics. SURG. CLIN. N. A. *26*: 102, 1946.

22. Ward, C. E. Head and Neck Panel; Proc. of the Second Nat. Cancer Conf., p. 418; Am. Cancer Soc. Inc., 1954.

23. Ward, C. E., and Hendrick, J. Tumors of the Head and Neck. p. 292. Williams and Wilkins Co., Baltimore.

24. Willy-Meyer, H. quoted by Ward (22).

25. Personal communication via Schetlin.

ESOPHAGEAL HIATUS HERNIA*

W. Burford Davis, M.D., John S. Harter, M.D., J. Ray Bryant, M.D.,
W. Fielding Rubel, M.D.
Louisville

AN HIATUS hernia must be repaired in the most physiologic manner possible to prevent recurrence of painful reflux esophagitis. It seems logical that this can best be done in most cases by re-establishing normal anatomic relations.

Hiatus hernia should be suspected in patients who present themselves with one or more of the following complaints: (1) substernal discomfort, that may vary from a feeling of fullness to a severe pain radiating from the epigastrium to the pharynx; (2) heartburn; (3) postural regurgitation; (4) varying degrees of dysphagia; (5) upper gastrointestinal bleeding, generally of the slow type and 6) anginal pain. Hiatus hernia, truly, is the great imitator of upper abdominal complaints. However, it does seem surprising that an average of three previous erroneous clinical diagnoses had been made in Harrington's 320 cases before the correct diagnosis was established.[1]

The high incidence of hiatus hernia has been well demonstrated by Brick who found an 8.93 per cent incidence in 3,448 roentgenologic examinations of the upper gastrointestinal tract.[2] Texter and associates believe the incidence in elderly patients may be as high as 33 per cent.[3]

It is the purpose of this paper to comment on the several types of operations we have done for hiatus hernia and to emphasize the importance of achieving a competent esophagogastric junction.

Anatomy

Recent careful work has demonstrated the erroneousness of the old conception that the esophageal hiatus of the diaphragm was made up of fibers from the right and left crura of the diaphragm.[4, 5] Allison[4] has shown that the esophageal hiatus is formed from fibers of the right crus alone. This structure acts as a sling for the esophagogastric junction (Fig. 1), much as the puborectalis forms a sling around the anorectal junction. In 15 fresh cadaver dissections Madden[5] found no incidence in which the left crus participated in the formation of the esophageal hiatal ring. Characteristically, the

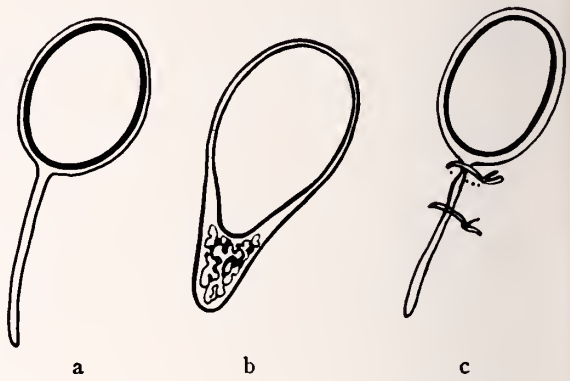


Fig. 1. (a.) Diagramatic representation of the right crus of the diaphragm split to form the esophageal hiatus, (b.) Represents the further splitting of the crus when a hiatus hernia occurs, (c.) Restoration of the hiatus by light suturing of crural fibers behind the esophagus.*

right crus is longer, thicker and more tendinous than the left, and arises from the upper three lumbar vertebrae (Fig. 2).

There is no sphincter at the esophagogastric junction. It is the function of the diaphragm

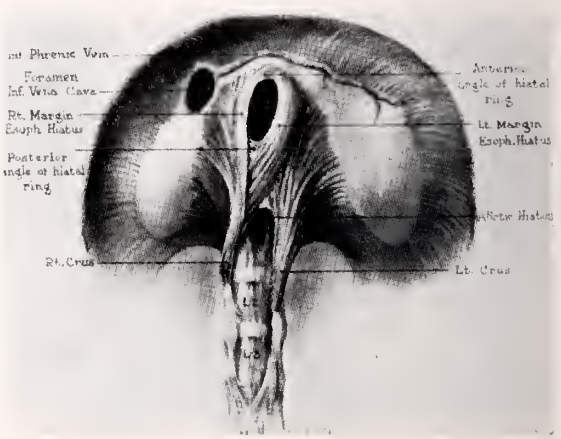


Fig. 2.*

alone to provide a sling for the esophagus that permits food to pass from the esophagus into the stomach and prevent the reflux of gastric contents into the esophagus. It can be easily seen how an hiatus composed only of fibers of the right crus can produce a more competent extrinsic sphincter than could fibers of two groups.

Presented at the May 19, 1956 meeting of the Kentucky Surgial Society at French Lick.

Phrenicotripsy

Phrenicotripsy, as the only form of surgical therapy for hiatus hernia, is generally limited to those patients who have severe symptoms but present a serious risk for an anatomic repair of their hernias. A left phrenic nerve crush is generally regarded as a temporary palliative form of surgical treatment. In reviewing the cases of hiatus hernia treated by surgery at the Massachusetts General Hospital, Soutter found five cases in which phrenicectomy was the only surgical therapeutic measure employed.[6] Marked immediate symptomatic improvement was noted in each case. In the three cases followed a year, there was complete recurrence of symptoms.

Although phrenemphraxis is generally employed in patients when the risk of a major operation is great, careful consideration of the patient is essential before recommending even this minor procedure. In patients with a low respiratory reserve, a phrenic nerve crush may be fatal. Also, strangulation of hiatal hernias has followed phrenicotripsy.

On first appraisal a surgeon may be tempted to recommend a phrenic crush, but after more careful consideration it becomes apparent that anything less than an anatomic repair would be ill advised. A recent patient, who is not included in this series, falls into this group. She is a 72-year-old woman who was not psychologically suited to undergo a major surgical procedure. (Fig. 3) After careful evaluation of her severe symptoms and the extremely large size of her esophageal hiatus, a repair was advised and has been successfully carried out.



Fig. 3. A hiatus too large for more than slight symptomatic improvement from temporary phrenic nerve crush.

Ten patients, who have been treated by left temporary phrenic crush, are presented. The results are evaluated in Table I. The youngest of these patients was 34 and the oldest 88. The 34-year-old patient was a pregnant woman who was having severe bleeding from peptic esophagitis. The result in her case is classified as poor as her hernia had to be repaired in one month because of severe vomiting with incomplete obstruction. The 88-year-old patient had maintained a good result when last heard from at age 92. A 72-year-old woman received 40 to 50 per cent relief but later at her request underwent surgical repair of her hernia. These results indicate phrenicotripsy to be a useful procedure in poor risk patients with moderately severe symptoms.

TABLE I

RESULTS OF PHRENICOTRIPSY	
Excellent	0
Good	6
Fair	3
Poor	1
Total	10

Surgical Repair

In reviewing the cases of surgically treated hiatus hernia at the Massachusetts General Hospital, Soutter found the recurrence rate had been 14 per cent after transthoracic repair and at least 40 per cent following abdominal repair.[6] Harrington, who advocates the abdominal approach, reports only nine recurrences and a 2.2 per cent mortality in a series of 320 cases.[1] Although he prefers the abdominal approach in all cases he states, "the technical difficulties of adequate exposure of the esophageal hiatus are often considerable because of the fixation of the left lobe of the liver to the leaf of the diaphragm." He further comments on the frequency of adherence of the spleen to the posterior portion of the diaphragm and hernia opening. Recently Beardsley has advocated repair of hiatus hernia from below. He feels that the poor-risk patient tolerates the abdominal approach better than the thoracic approach.[7]

Also he cites 28 concomitant lesions that were operated upon in 51 patients who underwent transabdominal repairs of hiatus hernias. He feels the 28 concomitant lesions would have required separate operations if the transthoracic approach had been employed for hernia repair. Beardsley feels more hiatus hernias should be repaired because they become larger and symptomatic at an age when the operative risk is increased. Therefore, one feels some of the concomitant lesions must have represented the primary cause for operation.

Unless a satisfactory repair is obtained the complications of stricture or recurrence with esophagitis may present a very major problem in a very unhappy patient. The adequate exposure and the technical ease of a transthoracic repair certainly contribute to the best possible repair. We feel the frequently mentioned postoperative complications of thoracotomy are greatly exaggerated and agree with others that the advantages of a transthoracic repair definitely outweigh any disadvantage of the approach.[6, 8, 9, 10]

In this series of 52 patients (Table II) treated surgically for hiatal hernia 6 patients have had a new hiatus established in an anterolateral position in the diaphragm as described by Merendino, Varco and Wangensteen[10] and

Table II

CASES OF HIATUS HERNIA TREATED SURGICALLY	
Phrenic Crush	10
Establishing A New Hiatus	6
Allison Repair	36
Total	52

previously commented upon by Wangensteen[11] in 1944 and Singleton[12] in 1942. These 6 patients have been followed from 1 to 5 years (Table III). One patient had a recurrence after

Table III

RESULTS OF REPAIR BY ESTABLISHING A NEW HIATUS IN AN ANTERIO-LATERAL POSITION				
Excellent	Good	Fair	Poor	Total
2	3	1	0	6

3½ years. Patients, although greatly improved, continued to have mild symptoms. While results with this procedure have been reasonably satisfactory, the operation leaves something to be desired as in some cases there is a lack of satisfactory tissue for closing the old hiatus. It is feared a hiatus hernia might be traded for a periesophageal hernia resulting from ineffective closure of the old hiatus.

Of the 52 cases in this series 36 have been treated by the procedure described by Allison. The esophageal hiatus is exposed and the extended phrenoesophageal ligament and peritoneal reflection about the cardia are divided (Fig. 4). After cleaning the divided right crus



Fig. 4. Two fingers of the left hand passed through the incision in the diaphragm and up through the hiatus to act as a guide while the phrenoesophageal ligament and peritoneal reflection are divided in front and on each side of the hernia.*

of the diaphragm, the hiatus is narrowed to the appropriate size by approximating the crural fibers of the right crus behind the esophagus (Fig. 5). The cuff of the phrenoesophageal

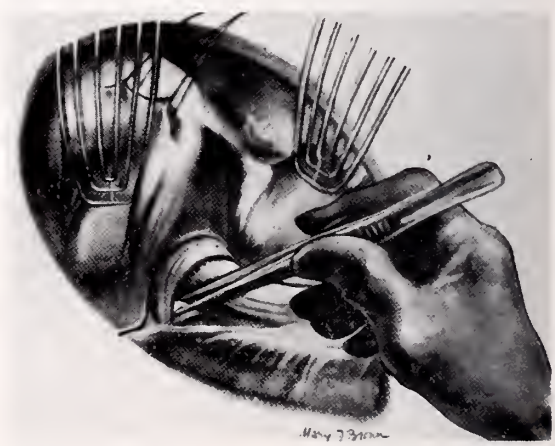


Fig. 5. Muscle sling of the right crus exposed and cleaned. The fibers are loosely approximated in their natural position behind the esophagus after the hernia has been reduced.*

ligament and peritoneal reflection about the cardia is then sutured to the under surface of the diaphragm. To accomplish this, Allison advocates the use of an incision in the dia-

phragm for the insertion of two fingers to be used within the abdomen for traction on the stomach and for better demonstration of the phrenoesophageal ligament. In the majority of cases the incision in the diaphragm has not been required. However, the use of traction from the abdominal aspect of the diaphragm is of definite advantage in the more tedious cases.

Allison has emphasized that this method permits the muscle fibers of the hiatal sling to continue to function physiologically thus re-establishing the competence of the cardia.[4] This procedure seems simpler as well as being more physiologic than the older method of placing sutures both to the right and left of the esophagus.

We are well pleased with the Allison repair after using it in 36 cases. Technically it is an easy procedure and frequently does not require more than 1½ hours. In general, the results have been satisfactory (Table IV). One of the

Table IV

RESULTS OF ALLISON TYPE REPAIR

Excellent	5
Good	21
Fair	4
Poor	2
Died	2
Total	36

two deaths was due to pulmonary embolus. The other was in an obese 70-year-old woman who had a recurrence of her hernia with obstruction while in the hospital. Following a second repair she died of a hepatorenal syndrome. This patient had a short esophagus. In retrospect the surgeon (W.B.D.) was probably too enthusiastic about the Allison repair and should have made a new anterolateral hiatus even if a small portion of the stomach had to be left above the diaphragm. In talking with Allison recently, he said that the great problem with the repair (Allison type) is in the occasional case of a definitely short esophagus.

Three patients in this group developed hiatal hernias following other surgical procedures on the lower esophagus. Of the four poor results two were in alcoholics who had previously had Heller operations for achalasia, then developed hiatus hernias which were repaired and subsequently recurred. Both underwent a second repair; one with a good result, while the other continued to have severe esophagitis. The two remaining poor results had partial recurrences with moderate recurrence of symptoms.

Discussion

Too frequently hiatal hernia repairs are considered successful when the radiologist reports that the stomach remains below the diaphragm in the Trendelenburg position. Unless the patient is free of substernal discomfort, heartburn, postural regurgitaiton and other characteristic symptoms he probably has an incompetent cardia. Where these symptoms persist, although the stomach remains below the diaphragm, the result of the operation should be considered poor. Such a patient probably has esophagitis and may become increasingly uncomfortable.

To insure competence of the cardia every possible effort should be made to make the repair approach normal anatomy as closely as possible, thus producing a physiologic cardia. We feel this can best be accomplished by an Allison type repair.

The need for repair of a hiatus hernia cannot be determined by the size of the hernia alone. Many patients may have more severe symptoms from a small hernia than others experience from a much larger hernia. The following case serves to illustrate this point:

Case I: Mrs. W.E.E. was a 50-year-old woman who helped her husband some in his office and did a moderate amount of club work.

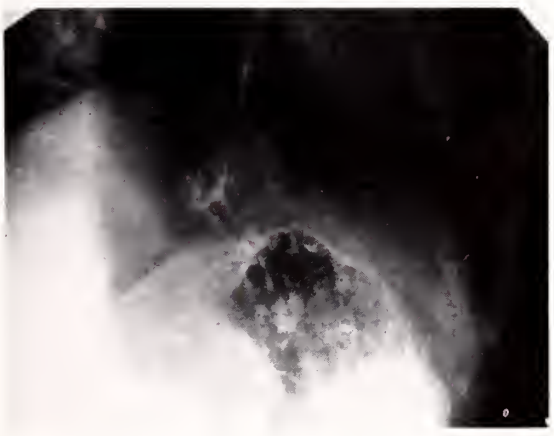


Fig. 6. Small hernia causing severe symptoms.

She had a small hiatus hernia (Figs. 6 & 7) that caused severe heartburn, intermittent severe dysphagia with vomiting and occasional mild bleeding. She had an Allison repair 20 months ago and has been completely relieved of all symptoms.



Fig. 7. Another view of patient in Fig. 6.



Fig. 8. Obese patient with marked anemia from bleeding peptic esophagitis. Repaired with good result. Patient represented an undesirable risk.

Good results may be obtained under extremely adverse conditions as in the following case (Fig. 8).

Case II: Mrs. O.G. was a 64-year-old woman whose height was 4'11" and weight 170 lbs. When first seen, her RBC was 1,700,000. This was the second time in three months that she had gradually bled down to less than 2,000,000 RBCs. In addition to weakness she complained of postural regurgitation, substernal discomfort, heartburn and dysphagia. Her hernia was a large one and her esophagus slightly shortened. Following an Allison repair 16 months ago she has had no more bleeding and at least 90 per cent regression of her other symptoms.

Conclusion

Vigilance must be employed in selecting patients for hiatus hernia repair. This can only be done by a careful work up, thus ruling out the lesions that produce symptoms characteristic of hiatus hernia. The repair should be as anatomical and physiologic as possible to insure competence of the cardia. We feel this most essential feature of a successful repair, competence of the cardia, can best be achieved in most patients by an Allison type repair.

Reference

1. Harrington, Stuart W.: The Surgical Treatment of the More Common Type of Diaphragmatic Hernia: Esophageal Hiatus, Traumatic, Pleuroperitoneal Hiatus, Congenital Absence and Foramen of Morgagni. Ann. Surg., 122: 546-568, 1945.

2. Brick, Irvin B., Incidence of Hiatus Hernia and Associated Lesions Diagnosed by Roentgen Ray. Arch. Surg., 58: 419-427, 1949.

3. Texter, E. Clinton Jr., Smith, Hubbard W., Sippy, H. Ivan and Bardorka, Clifford J.: Hiatal Hernia and Related Disorders of the Esophagogastric Junction. J A M A, 160: 830-833. March 10, 1956.

4. Allison, P. R.: Reflux Esophagitis, Sliding Hiatal Hernia and the Anatomy of Repair. Surg. Gynec. and Obst. 92: 419-431. April, 1951.

5. Madden, John L.: Anatomic and Technical Considerations in the Treatment of Esophageal Hiatus Hernia. Surg., Gynec. and Obst. 102: 187-194. February 1956.

6. Soutter, Lamar: An Analysis of the Cases of Hiatus Hernia Treated by Surgery at the Massachusetts General Hospital. Surg., Cl. of N. America 2715: 1121-1127, October 1947.

7. Beardsley, J. Murray.: Esophageal Hiatus Hernia, Repair from Below. New Eng. J. of Med., 92: 409-412. March 1, 1956.

8. Sweet, Richard H.: The Repair of Hiatus Hernia of the Diaphragm by the Supra-diaphragmatic Approach.

9. Sweet, Richard.: Thoraci Surgery. W. B. Saunders Company, 1950.

10. Merendino, K. Alvin, Varco, R. L., and Wangensteen Owen H.: Displacement of the Esophagus into a New Diaphragmatic Orifice in the Repair of Paraesophageal and Esophageal Hiatus Hernia. Ann. Surg. 129: 185-197. Feb. 1949.

11. Wangensteen, O. H.: In a discussion of a paper by Carey, J. B., presented before the Minnesota Academy of Medicine, December 13, 1944. Minnesota Med., 28: 1945.

12. Singleton, A. O.: In a discussion of a paper by Harrington, S. W. Diaphragmatic Hernia of Children. Ann. Surg. 115: 705-715, 1942.

*With permission of Surgery, Gynecology and Obstetrics.

From the Department of Surgery of the University of Louisville School of Medicine and the University of Louisville Hospitals.

WEDGE AMPUTATION FOR GUNSHOT WOUNDS OF THE METATARSUS AND METACARPUS

ROBERT W. AUGUSTINE, M.D. AND MERLE MAHR, M.D.
Madisonville

GUNSHOT injuries to the hand or to the foot are frequent hunting accidents. This article deals with one type of hand and foot gunshot injury, namely that involving one or several rays* of the metatarsus or the metacarpus. They usually result from a muzzle blast of a shotgun or the effects of a rifle ball. Conservative treatment of the wound, that is the retention of all viable parts, when the usefulness of one or more rays has actually been destroyed, results in unnecessary permanent crippling of the hand or the foot. Determination of the functional destruction of one or more rays followed by their amputation and prompt mobilization of the preserved remaining normal components results in optimum usefulness. (Figures 7 and 8).

Indications for Resection

The essential determination regarding the future integrity of a ray of the hand or foot is made at the time of primary surgery. Criteria indicating primary resection of the entire ray are as follows: the irreparable loss of both digital sensory nerves, or the loss of both digital



FIGURE 8



FIGURE 7

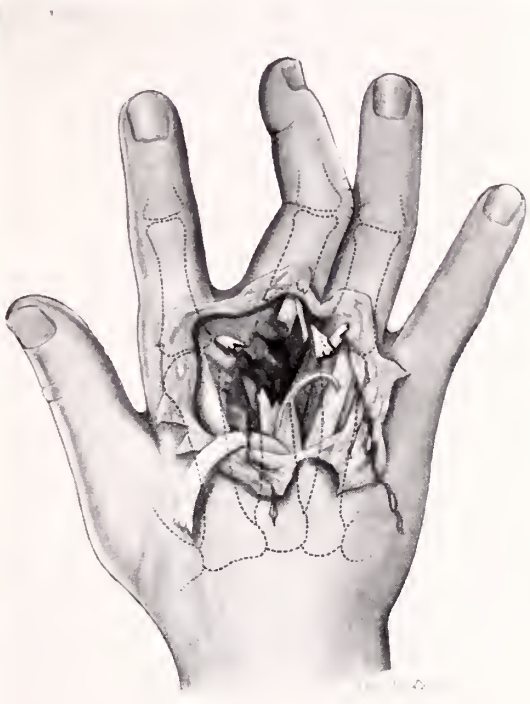


FIGURE 1

*The metacarpal and its phalanges, and the pertinent contiguous functional soft tissue parts in the hand, compose a ray.

arteries, or the loss of considerable metatarsal or metacarpal bone combined with tendon damage and the destruction of the metacarpo- or metatarso-phalangeal joint, or the destruction or impairment of the flexor tendons.

Shotgun muzzle blast injuries usually result from grasping the muzzle of the gun with concurrent detonation of a shell in the chamber. This creates a wound of entrance about the size of the gage of the shell but a rather larger wound of exit on the opposite side of the hand (Figures 1 and 2). Considerable destruction in the path of the missile exists. Occasionally this occurs when the individual stumbles while walking or the muzzle of the gun is placed near the foot in getting in or out of an automobile.

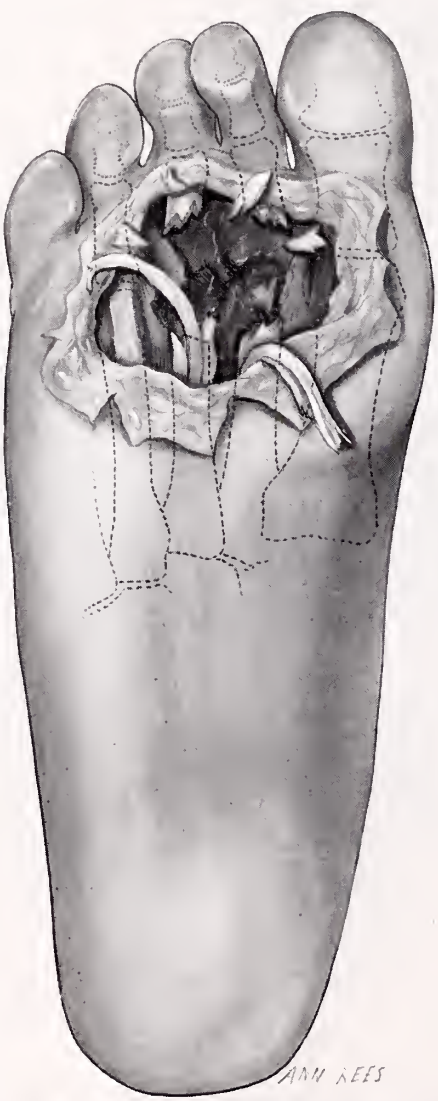


FIGURE 2

A ball from a rifle usually creates destruction by the bursting effect of shattered bone fragments.

These injuries are characterized by apparent viability of the fingers or toes of the involved rays when actually useful function has been destroyed. The retention of the impaired fingers or toes with the distal portion of their ray, may lead to healing of the wound and their survival. Disability then appears in the foot with hammer-toes and painful callosities on the plantar surface of the forefoot (Figure 3). In the hand the ultimate damage is exemplified by inability to flex the affected finger or fingers upon the palm and compromise of joint function in the remaining digits which were not damaged by the initial gunshot wound. The retention of damaged parts, and their immobilization during the period of the healing, leads to fibrosis from the effects of hemorrhage and anoxia, resulting in fibroplasia and adhesion of the small moving surfaces in the hand and foot. These adverse changes occur also in contiguous normal structures, ultimately augmenting the terminal disability. This ancillary final handicap is increased by injudicious immobilization; the result burdening the hand or foot with useless digits plus the additional impairment of sound structures. In the hand fine movements are lost. In the foot toe flexion is lost with resulting trauma to the plantar forefoot in walking. The adhesion of these small moving surfaces involving the tendons and the joints and their capsules is frequently a permanent situation, and is always so in the digit that has received moderate damage to the flexor tendon apparatus. In the hand the intrinsic musculature is necessary for proper function of the fingers and loss of their deep ulnar motor branch will impose a permanent handicap upon the hand. The



FIGURE 3

loss of the deep ulnar motor branch, however, does not constitute an indication for ray resection. In the foot the intrinsic musculature is not so important as in the hand, and should the motor nerves to the short muscles of the foot be lost effective toe flexion may be achieved by reparative surgery which will result in a useful forefoot, providing the long flexor mechanism is intact.

In the foot the medial and lateral plantar nerves innervate the short muscles and correspond in the hand to the deep ulnar motor branch, but carry in addition the important volar sensory digital nerve supply. The medial and lateral plantar arteries accompany the nerve and their competence should be determined at the time of initial surgery. However the loss of a medial or lateral plantar artery is not disastrous due to the rich anastomotic supply from the surviving plantar branch and from the dorsalis pedis artery. In the hand one palmar arterial arch may take over the nutritive function of the other, but the loss of both digital arteries suggests ray amputation.

Operative Procedure

The decision regarding amputation having been made, the operative procedure is fairly simple and proceeds as follows: the ray or rays

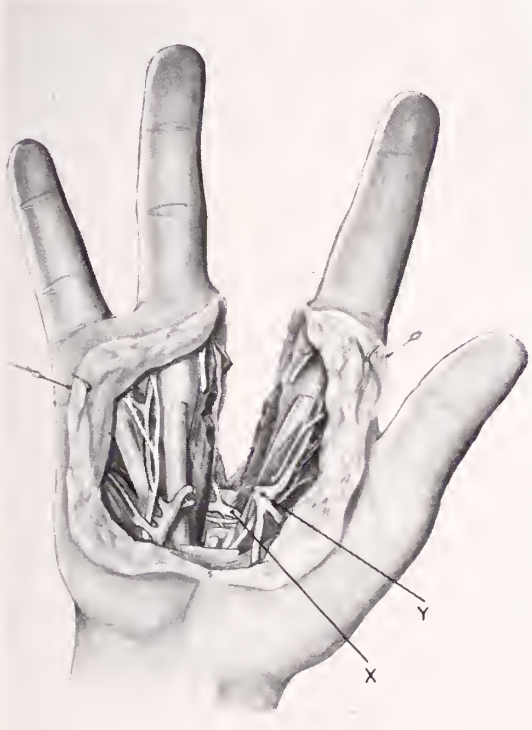


FIGURE 4
X is the deep motor ulnar branch
Y is the superficial palmar arterial arch

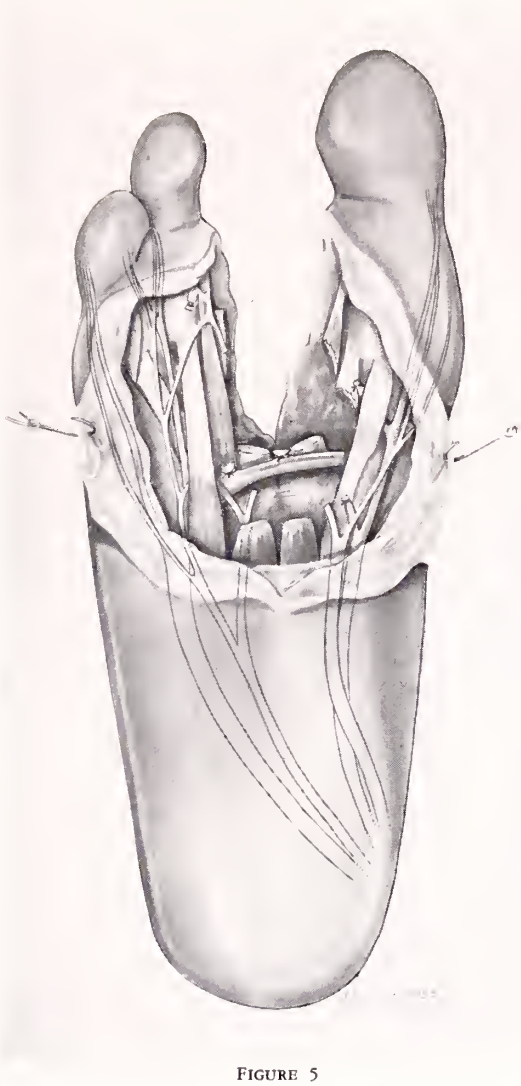


FIGURE 5

to be amputated are removed to the carpus or the tarsus, with preservation of all viable skin and soft tissue (Figures 4 and 5). Sacrificed tendons should be pulled down, severed cleanly, and allowed to retract. Care should be taken not to damage remaining sensory digital nerves or vessels and particularly the motor ulnar nerve which lies upon the palmar aspect of the metacarpal bones. The remaining portions of the hand or foot may then be approximated and held with several sutures (Figure 6). The primary closure of gunshot wounds is not ordinarily recommended but is applicable under the above circumstances because apposition of the opposing surfaces is necessary for primary healing and early function and because the closure is loose and allows adequate drainage. Should the amputation involve the medial or the lateral aspects of the foot the ray is resected to the tarsus and soft tissue closure is affected. The retention of the motor flexor function of

the great toe is desirable but this ray should be resected if the above criteria exist. In the hand the thumb with its opposing function should be retained unless gangrene supervenes. The hypothenar area of the hand in a working man may be retained to act as an opposing buttress in relation to the thumb in gripping. In the woman the greater part of wisdom may be the resection of the entire ray on the ulnar side of the hand and the creation of a symmetrical countour from the carpus to the base of the remaining fingers.

An essential part of the ray amputation principle, following destructive gunshot wounds, consists of active mobilization of the normal remaining structures following the surgical procedure. This consists of immediate active exercises of flexion and extension of the remaining toes or fingers following the operation. Within several days the affected part is placed in a whirlpool to encourage by the use of heat and hydro-massage the essential functions of flexion and extension of the digits. There is little pain associated with this plan. This requires the active and aggressive participation on the part of the patient. The function of the toes or fingers once gained is never lost, however the regaining of function after the appearance of fibrosis following immobilization is a matter of uncertainty. Continuous elevation of the part to avoid congestive edema is advised.

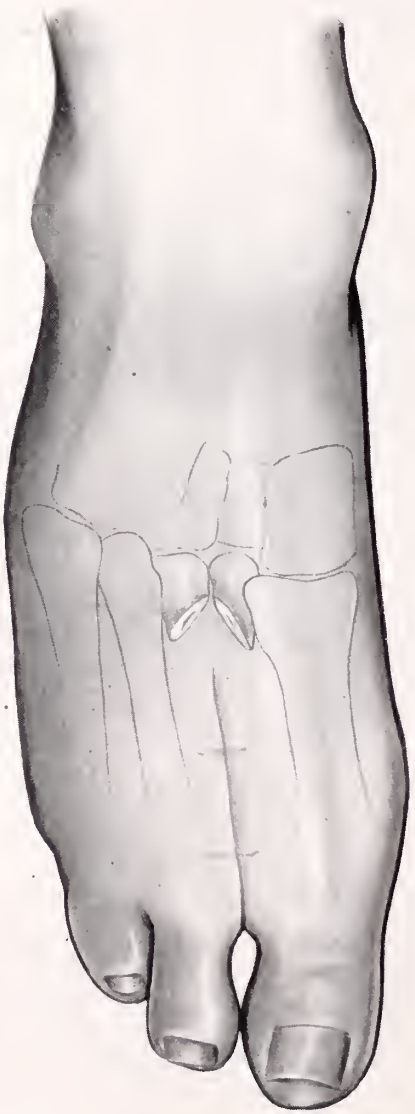


FIGURE 6

The principles herein expressed conform with recent attitudes recorded in "The Manual of Therapy, European Theater of Operations," by Mather Cleveland et al.,[1] who advised early closure of hand wounds, placed emphasis on early mobilization of the injured hand, prompt action if amputation is indicated, placed early function over perfectly reduced fractures, retention of all possible parts of the thumb, and utilization of physical therapy.

Summary

The authors have recorded their suggested treatment for gunshot wounds involving one or several rays of the metatarsus or metacarpus as follows: determination at the time of primary surgery of the existence of damage to essential component parts of the affected rays that would result in their subsequent lack of function, and radical resection of the affected rays followed by loose primary closure of the wound and prompt mobilization. This decision and action at the time of primary surgery is necessary to avoid future compromise of the hand or foot due to fibrosis in the small planes and dimensions of the fascial and tendon compartments. Ray amputation is indicated when there is irreparable loss of both digital sensory nerves, or both digital arteries, or loss of considerable metacarpal or metatarsal bone combined with tendon damage and the destruction of the affected metacarpal or metatarsal phalangeal joint, or moderate destruction of the flexor tendon apparatus. With the loss of one or more of the above elements the normal remaining fingers or toes suffer by interstitial fibrosis from inactivity associated with the healing process of

the wound and the damaged tissues. This results in hammer-toes and plantar callosities with painful weight bearing in the foot, and in loss of fine motions in the hand and the presence of a protruding useless finger. Reparative surgery for such conditions after healing has transpired is disappointing. The essential place of prompt physical therapy in this suggested plan has been pointed out. These suggestions have been prompted by observing disabled hands and feet as end results which we feel could have been materially improved by the above suggested ray amputation with primary closure and mobilization.

References

1. Cleveland, Mather; Manning, John G.; Stewart, William J., Journal of Bone and Joint Surgery, American Volume 33 A No. 2, April, 1951, Page 527 VII, Section C, "Care of Battle Casualties and Injuries Involving Bones and Joints."

ANXIETY*

H. Burl Mack, M.D.
Pewee Valley

NOW, Mrs. Jones, when we opened up your husband's abdominal confislan, we found the gorkinfus all wound around the colonic fishinloose, and it was necessary to remove about twenty-four feet of flexionoffen. I think he will be all right, but, of course, complications due to pneumokonikonkigus may set in, and in that case I will have to call in Dr. Horsesneck and we will, in all probability, have to dilate the capillissen bed and free up the cornified triumfexors. We plan on giving him the latest anti-factual ataraxikus, which is, of course, quite expensive, but I think your insurance will cover it. In these cases, it is always important to stabilize the equilibrium with Frenithoraquill, because otherwise gangrenous endofecal endarborization may set in. We are trying to prevent this by having extroverted the displacement of the component cephalocaudalwise, but in a case like this, anything can happen, and usually does. Now, don't you worry one little bit, but be sure and call me if there is anything else I can explain for you!

Gentlemen, this is an example of building up a terrific anxiety in a relative of a patient. Let us first discuss this anxiety which we all know exists in a patient's husband, wife, or others close to him.

Approach to the Family

We have been told from our medical school days that when we get out into practice we will find that we must treat the relatives as well as the patient. This part of my paper will deal with an approach to this problem.

If any of us have ever had a member of our family seriously ill, or who has had to undergo major surgery, we know how much we hang on every word of the attending physician as he talks to us about that relative. We can always imagine that the worst is going to happen, and, in the case of the Doctor's family, it usually does, plus complications. However, we are all prone to rate undue importance to every word or phrase of the reports given us by the man in attendance, and wonder if he is hiding anything, or even if he is telling us the truth.

Of course, we as Doctors, should know more than the average layman knows about medical terms, but we probably do not worry any more about the outcome of a surgical procedure or the progress of an acute medical condition than the loving wife or husband of our patient.

We are all too prone to more or less "put up with" the questions of the worried and well-meaning family, and do not sincerely and conscientiously try to understand their concern and to allay their fears.

When a dear one has been operated on, and is still under the effects of the anesthetic, the family members present are in a situation that they may never have faced before. They may ask questions that to us seem foolish, childish, or impossible to answer. Of course, we are in a hurry to get to the next case, or to the office being already late for the beginning of hours. We are concerned about the patient, not the relatives. "The patient is doing fine, stood the procedure wonderfully—Nothing to worry about, See you tomorrow!"

How much better to stop for just four or five minutes, and in an unhurried manner, explain in words of one syllable what has been done, what was found, and a hopeful outlook for the

*Presented at a meeting of the KSMA's Seventh Councilor District, May 31, 1956.
*Paper prepared by H. Burl Mack, M.D., and presented at the Seventh Councilor District Meeting, Frankfort, Kentucky, May 31, 1956.

future, if one exists. Surely this is no time for levity, or attempting to cheer up the apprehensive relative by joking or telling a funny story. Neither is it a proper time, if there ever is a proper time, to try to impress the relatives with the ability of the surgeon or the diagnostician in an attempt to get over the idea that, "It's a good thing that I operated when I did, or he would have been a dead pigeon," or, "It's a good thing I made the right diagnosis, or he never would have made it." "There's nothing so becomes a man, as modest stillness and humility." (Wm. Shakespeare). If the future course is dark, certainly some member of the family must be told, or perhaps the entire immediate family may be told at one sitting.

Approach to the Patient

The question so often arises, "How much can, or should I tell this patient about his condition, especially if it has a precarious or hopeless prognosis?" The family physician can be of the greatest help to the specialist or surgeon at this time. Knowing the patient, his family, his temperament, outlook, hopes and fears, helps so much in making use of the proper method or words to use in times of such stress. If a patient tells us soberly and straightforwardly, "Doctor, whatever you find, I want to know the truth," then surely he is entitled to be told the truth. If he does not make such a request, then the family should be taken into complete confidence and the problem discussed with them before telling the patient, if he is told at all. Anxiety over a questionable outcome can play havoc with the chances of a patient who is sorely in need of complete confidence in his family and his doctor.

Consultants

There is another means of preventing and of treating anxiety in the relatives as well as the patient. In all seriously ill patients, where a long hard pull is anticipated, or where the outlook is in question, offering to call in a consultant may relieve considerable anxiety. Many times the family and the patient will express complete confidence in the way the case is being handled. But a vote of confidence helps not only the doctor, but also proves to the patient and the family that you are humble and not all-powerful.

In these days of rapid medical advances, it is impossible for one mind to encompass the entire field of medical diagnosis and therapy, and be entirely right every time. People know this, and men highly trained in specialty fields know it. All of us have limitations, and we should recognize these limitations. If we offer to call in help, we have gained in stature in the eyes of the family, but if they make the suggestion, we may have lost just a little of their respect. If our diagnosis, methods and schedule are confirmed, all anxiety in this regard is dispelled. If something new is offered and the patient is benefited, you will be complimented on calling in help of the right sort, and everyone will be happy.

Louisville and our district is blessed with an abundance of excellently trained men who are well qualified and happy to help in any difficulty. We can all use them to advantage and relieve or prevent anxiety on the part of the relatives, the patient and ourselves.

Psychosomatic Aspects

Let us next consider the anxiety, or anxieties, of the patient we are treating, and how the soma is affected by the psyche. We all know that every patient who is physically ill is, to some greater or lesser extent, also mentally ill. Not psychotic, mind you, but his psyche (soul, spirit, or mind) is affected, and needs treatment. This is just as great a need as that which exists in his tonsils, when his throat is sore; or as great a need as exists in his coronary arteries when he has had a heart attack; or as exists in his bowel when his constipation needs treatment.

In these days of helter-skelter, hurly-burly activity, life is so full of anxiety and frustration that many patients can be helped more by a quiet, attentive ear listening to their story than by all the tranquilizers in the Commonwealth of Kentucky! Were we not taught by our illustrious professors, "Take time to listen to your patient and he will tell you what is the matter with him—the diagnosis will then be easy." Also, "Take a good history; it will often make the examination and laboratory work merely confirmatory—the patient has already told you the diagnosis! Do this, and the end result will show that much time and expense will have been saved."

People, these days, are professional worriers! They are not content to worry, as our fathers

did, about such trivial things as their job, their family, their crops and their neighbors. Now they, and we, must worry about not only local conditions, but about County, State, National and International happenings, and we must worry about them every day. We cannot avoid it. Our eyes are blinded by world conditions and problems by newspaper, magazine, and by television. Our ears are deafened by radio, public address systems and telephones constantly hammering at us lest we forget our global responsibilities. Is it any wonder that we are fast becoming famous for the speed that we can attain in developing ulcers, and how soon we can grow another one when we get the old one healed up?

How many of our patients are hyper-acid, hyper-active, hyper-bolic, hyper-critical, hyper-emic, hyper-irritable, hyper-piesic, hyper-sensitive, hyper-tensive, and hyper-tonic? Are they filled with anxiety, and do they need help? Can we help them? How?

Medicine and science have made great progress in the therapy of, and the prognosis for, anxious patients, especially those who are so overwhelmed by their frustrations and anxieties that they must be institutionalized and rehabilitated. But what of the dozens of patients that we all see every day and every week who are trying to keep going, trying to support and keep house for their families, trying to be happy, and who realize more and more every day that they are fighting a losing battle? Finally they will come to their doctor and say that they are sick; that life is getting too complex for them, and they need help. What are you going to do for them? What am I going to do for them? Give them a prescription for some Equanil®, or Serpasil®, or Thorazine® to tranquilize them, and then some dextroamphetamine to pep them up out of the depression that they go into from the medication? Perhaps, give them some barbiturate to sedate them, and then some desoxyephedrine or Wyamine® to make their mind more active? Are drugs the answer?

Some psychiatrists are very enthusiastic about those new members of our treatment list; others are more skeptical. The more conservative admit that although these agents are very wonderful in many cases, even as Electro-Shock therapy treatments are wonderful in many cases, we cannot yet turn our State and private mental institutions over to the Nursing Home Association for use as Old Folks' Homes. These afore-mentioned modalities do tend to shorten hospital stay, allowing for treating more patients with a given number of beds, but what of the patients we see who cannot be placed in institutions, sanitoriums, or even be put to bed at home?

The Dying Patient

There is another group of patients and relatives who fall in the anxiety group who also need our understanding and help. We are too often inclined to pass over lightly our responsibility, and advise them to consult their spiritual advisor. I refer now to the relatives of the elderly patient who is nearing the end of the trail, and who want the physician to do anything, or rather everything, to keep the patient from dying. Fortunately, we do not have this group to contend with so very often. But we do frequently see the patient who knows he does not have long to live, and who is afraid to die. Can we, as his physician, help this fear and anxiety? I feel that we can.

No one should be required to suffer if it is within our power to prevent this suffering. But when we see an elderly stroke victim nearing the end, should we put him in an oxygen tent, give him blood transfusions and cortisone to keep him here just a few days longer? True, our antibiotics and other medicines may already have prolonged his life many years, but if he cannot ever be a useful citizen again, cannot enjoy life or feel comfortable again, should we keep him on earth against his wishes, just because a selfish family is afraid to see him die? I feel that the approach to the family can be the same as to the patient who is fearful of dying.

We, as Christian physicians, should believe that the life hereafter is free from sickness, sorrow, fear and pain. If we really do believe this, need we fear death? It is primarily that we face an unknown, is it not, and are leaving something of which we have grown fond over the years? Let's talk up our faith, live our faith, and not be afraid to offer our faith to our patients and their relatives. Along with talking up our faith, having prayer with the patient who is seriously ill, or one who is about to have surgery will give them much more confidence in us and relieve their anxiety more than having their pastor pray for them.

What else can we do for these anxious pa-

tients who come to us for help? Do we have anything else besides prescriptions to give them? Yes, we do.

FIRST: We can listen sympathetically to their story—Offer a good right ear.

SECOND: We can offer them assurance that there is nothing physically wrong with them by doing a careful, thorough examination with appropriate laboratory work.

THIRD: We can offer them correction of any conditions that need treatment by appropriate measures, as within our power lies, or advise them where they can secure this treatment.

FOURTH: We can offer them confidence and hope for the future—that we are always glad to listen to them, glad to help them, to be available to them in their hour of need, God helping us, and them.

TO CLOSE: We can offer them our affirmed pledge to do our duty:

TO CURE OCCASIONALLY
TO RELIEVE FREQUENTLY
TO COMFORT ALWAYS.

THE JOURNAL

Factual—Informative—Meditative

"Reading furnishes the mind only with the materials of knowledge; it is thinking makes what we read ours."—Locke

---

This issue of The Journal includes useful material for provocative thinking on the part of KSMA membership.

In addition to carefully scheduled scientific articles, book reviews, case discussions and editorials, you will find timely local advice from your State president and pertinent happenings in Washington that may affect your practice.

Read into the Annual Meeting stories more than names and dates and topics. Important issues confront Kentucky physicians between the lines. There are bylaw changes and plans to improve your State organization, the significant Medicare program, the labor warnings, the Rural Health needs. You may consider Kentucky's great opportunity for medical progress in expanded training and hospital facilities. Yet, trace through it all the binding ties of the Commonwealth's medical traditions.

You will feel a pride in your new officers and committees, your honor recipients, and in the recognition of local doctors beyond the borders of the Blue Grass State. Garner to yourself the security being felt in various areas through the introduction of new practitioners. Grasp something of the loss of those whose black bags are forever closed. Take hope in the promise of perpetual Kentucky practice through the column of the Student AMA.

It is difficult for doctors to schedule reading time. Yet every Kentucky physician wants to keep abreast of the changes affecting him in today's world. This is The Journal's objective: to bring you the latest in State medical information in a manner to encourage reading according to time and need—concise news stories for rapid digestion, technical articles for more serious reflection.

KEEP UP-TO-DATE! READ THE JOURNAL

CASE DISCUSSION FROM THE UNIVERSITY OF LOUISVILLE HOSPITALS

AFIBRINOGENEMIA FOLLOWING DELAYED POSTPARTUM HEMORRHAGE

Patient Protocol

E. P., a 21-year-old white para 3, was first seen on July 10, 1956, three weeks after an apparently uncomplicated delivery at home. Postpartum bleeding was moderate only, and had stopped completely on July 9. At 1:00 P.M. on July 10, there was sudden profuse vaginal bleeding. This continued throughout the afternoon, and was still going on when she was brought to the Emergency Room at 6:15 P.M.

Physical Findings:

The physical findings at the time the patient was first seen were those of a woman in deep hemorrhagic shock. The blood pressure could not be obtained. The pulse rate varied between 140 to 160 beats per minute. The skin was cold and clammy, and there was slight circumoral cyanosis. The vagina contained a large amount of clotted blood; it was free from laceration or other lesion. The cervix was soft and widely dilated. The uterus was enlarged to the size of a two to three months' pregnancy, and was soft and boggy in consistency. The uterine cavity was filled with clotted blood.

Treatment and Course in the Hospital

Immediate management consisted of the intravenous administration of dextran and preparations for whole blood transfusion. Pitocin and methergine were given for oxytocic stimulation, but without success. About ten minutes after the patient reached the ward, circumoral cyanosis had become extremely marked, and there were signs of air hunger. Oxygen was administered by mask, and whole blood was administered under pressure. Fifteen minutes later, uterine curettage was done, and a very small amount of retained placental tissue was removed from the posterior uterine wall. After the curettage, hemorrhage continued as before; there was no contraction of the uterus, and the amount of bleeding was such that blood could not be replaced as fast as it was being lost. Uterine massage, exhibition of oxytocics, and administration of a hot saline intrauterine douche all failed to improve the situation.

At 9:00 P.M., an emergency abdominal hysterectomy was performed. By 10:02 P.M., when the operation was over, the patient had received a total of 16 units of whole blood. During the hysterectomy, bleeding occurred from a small laceration in the friable tissues around the vaginal cuff, and it was noted at this point that the blood lost did not clot. Hemostasis by ligature was apparently successful for a time, but after the abdomen had been closed, vaginal bleeding persisted. A vaginal speculum was inserted, and a small laceration in the area of the cuff was sutured; bleeding then was seen to occur from the points of insertion of the ligature. A pack placed in the vagina was soon saturated with blood. Reinspection of the vagina showed only multiple areas of bleeding from the cuff margins; there was no specific major bleeding point. At this time, it was noted that similar bleeding was occurring from the edges of the abdominal incision. The bleeding tendency was not modified in any way by the administration of seven grams of fibrinogen. The blood pressure continued unobtainable, and the administration of Vasoxyl and Levophed failed to elevate it.

During the ensuing six hours, the patient lost consciousness and her breathing became labored. The chest was clear to auscultation. Oozing continued from all traumatized surfaces, including needle puncture marks. The pulse rate remained at 160 until 4:45 A.M., when gallop rhythm developed and the patient expired. Permission for autopsy was refused.

Discussion

Thomas D. Stevenson, M.D.

Examination of the blood following the onset of the hemorrhagic diathesis following the hysterectomy showed that the blood was totally incoagulable. The addition of an excess of thrombin to the blood did not result in clot formation. The addition of fibrinogen, however, resulted in prompt clotting of the patient's blood *in vitro*. These studies showed that the basic defect in hemostasis was a deficiency of fibrinogen. The mechanism of the hypofibrinogenemia in this particular instance is not entirely clear, but it would seem unlikely that the

(Continued on Page 971)

ACHROMATIC



ACHROMYCIN*

Tetracycline *Lederle*

for prophylaxis and treatment of

obstetric infections

Posner and his colleagues[1] have reported on the use of tetracycline (ACHROMYCIN) in 96 cases of obstetric complications, including unsterile delivery, premature rupture of the membranes, endometritis, parametritis, and other conditions. They conclude that this antibiotic is ideally suited for these uses.

Other investigators have shown ACHROMYCIN to be equally useful in surgery and gynecology and virtually every other field of medicine. This outstanding antibiotic is effective against a wide variety of infections. It diffuses and penetrates rapidly to provide prompt control of infection. Side effects, if any, are negligible.

Every gram of ACHROMYCIN is made* in Lederle's own laboratories and offered *only* under the Lederle label—your assurance of quality. It is available in a *complete* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection, bolsters the patient's natural defenses, thereby speeds recovery. Especially useful in severe or prolonged illness. Stress formula as suggested by the National Research Council.

SF Capsules, 250 mg.

SF Oral Suspension, 125 mg. per teaspoonful (5 cc.)

dry-filled sealed capsules

For more rapid and complete absorption. Offered only by Lederle!

[1]Posner, A. C., *et al.*; Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

PHOTO DATA: SPEED GRAPHIC CAMERA, F.16, 1/50 SEC., RDYAL PAN FILM

EDITORIALS

AUTOMOBILE SAFETY

WHEN CAN WE control a foremost killer in our age? We have major and ever increasing drives for funds to abolish the dread ravages of disease and blightly watch a foremost reaper take an ever increasing toll of life and limb.

The rapidity of disaster is frightening, a momentary lack of attention or indecision can and frequently does turn loose a ton and a half monster capable of great destruction. It is a known fact that a pilot on an airliner requires at least a mile to avoid a crash with an approaching plane, and it seems as though automobiles are rapidly approaching the same fate.

It seems more and more time is required in repairing minor and major injury produced by automobile crashes, a type of injury that is both time consuming and tension producing, and proves to upset any attempt at order.

With the advent of the state and national subsidized superhighway system, the probability of excessive speeds apparently attempting to keep up with the speed of aircrafts, there is certainly a pressing and urgent need for newer and better safety devices if humans are expected to survive the sudden stops associated with crashes of the car to car, car to tree variety, and car to whatever may be ahead of an uncontrolled vehicle.

Can the problem be controlled? Some improvement has already been effected through efforts largely by organized medical groups. There are studies for determining the type and severity of injury to be expected and for safety features to decrease the injury. However, they are too slowly received by the great number of automobile owners. Eye catching lines, style, and tremendous horsepower are much more important than are safety features. Drivers must be educated, voluntarily and forcibly, when necessary, as to their responsibility. Mandatory schools for accident prone drivers, more rigid physical qualifications and enforcement are certainly needed, as now a person incapable of even walking may drive an automobile whenever he desires.

Mechanical features are secondary to the human element but are necessary if the toll of death and destruction is to be reduced. Control of airborne craft is and has been for a number of years a reality. Surely the need for added and increasing safety features in automobiles is clear.

We, as physicians, can do much as individuals in our daily contacts to further the use of safety devices, as seat belts, padded crash panels, safety doors for automobiles. Rarely a day passes that I am not requested to express an opinion on these "newer life savers."

Our state and national organizations can go even further in advocating the use of safety factors as many individuals do not feel that these added safety devices are really helpful in reducing the severity of injury in cases of collision.

John J. Sonne

EXCISION OF THE RECTUM: TWO TEAM TECHNIC

ON THE SEVENTH of January 1907 William E. Miles of London performed the first planned radical operation for excision of the rectum and lower colon. This operation consisted of removal in one piece of a segment of colon, the rectum, and a wide area of mesentery harboring the lymphatic vessels and nodes that drained the rectum and lower colon. This necessitated a permanent colostomy. Before performing such a radical operation Miles had studied thoroughly the structure of the lymphatic vessels and nodes of the rectum and adjacent areas and the metastatic spread of rectal diseases. By means of his studies of the anatomy and pathology of cancer of the rectum, Miles placed the treat-

ment upon sound basis just as Halsted had done years previously for cancer of the breast. Since then many others have confirmed Miles' studies and the operation of abdominoperineal excision of the rectum and lower colon often called the Miles operation is the best treatment for this disease which without operation is lethal, dreadfully painful and offensive.

Miles performed the abdominal and perineal portions of the operation in one stage. He did the abdominal part first, pushed the liberated colon into the pelvis, sutured the pelvic peritoneum above it, closed the abdominal wall and turned the patient upon his side in the lateral Sims position and removed the anus, rectum and colon through the perineum. Other surgeons would turn the patient to the prone position for the perineal part of the operation, as this afforded a better view of the structures and was easier technically. The turning of the patient either upon the side or to the prone position nearly always resulted in a marked and often serious drop in blood pressure. Because of the drop in blood pressure some surgeons would perform the perineal portion of the operation with the patient in the lithotomy position in which the body is supine with the legs elevated and the buttocks at the lower edge of the table. This was a definite improvement though it still necessitated suturing the pelvic peritoneum over the liberated colon during the abdominal part of the operation with change of position and draping for the perineal part. Though there was no appreciable frequency of lowering of the blood pressure in changing to the lithotomy position there was a tendency to interference with respiration when the thighs were flexed acutely particularly if the patient was obese.

To obviate the difficulties of dividing one operation into two parts with the undesirable features just enumerated Lloyd-Davies of England in 1938 advocated and performed the Miles operation employing two teams of surgeons, the abdominal and perineal portions being executed simultaneously. Only one draping and one positioning of the patient was necessary as the patient was placed in a modified lithotomy position at the beginning of the operation with the thighs slightly flexed and abducted with the knees supported in crutches fastened to the lower end of the table. The perineal portion was not started until the inferior mesenteric artery had been ligated as it was soon learned by experience that there was less tendency to shock than when the two parts were started at the same time. With two teams operating at one time, less time was consumed, the structures in the depths of the pelvis were more readily and clearly exposed, the closure of the pelvic peritoneum was done with less tension and greater ease, and there was definitely less tendency to elevation of the pulse rate and depression of the blood pressure. The execution of the abdominal part was not hampered by having thighs flexed and abducted. Laufman, Bettman, Flint, Dragstedt and others in this country have used this method and confirmed Lloyd-Davies' findings and conclusions.

We have now performed the two-team one-drape and one-position operation a sufficient number of times to endorse it and recommend it to other surgeons. If desired, great lengths of colon can be removed even to the mid-transverse region or beyond which would be impossible by the older method without two divisions of the colon as the segment would be too large to push in the pelvis even temporarily. In the past, several attempts have been made to perform the perineal part first and though it can be done, it was proven unsatisfactory as there is less bleeding and technical difficulty when the rectum is mobilized and blood supply controlled from above before beginning proctectomy. The thighs should not be flexed acutely but should be abducted widely. A self-retaining catheter can be brought over the right thigh without entering the field prepared for the operation. Special care should be taken to pad the crutches to prevent pressure upon the peroneal nerve.

Malcom Thompson, M.D.
Blaine Lewis, M.D.

Case Discussion

(Continued from Page 967)

hypofibrinogenemia is related in any more than a casual way to the excessive postpartum bleeding. The appearance of hypofibrinogenemia associated with abruptio placentae and septic abortions, has recently been described. Such an episode, however, has not been documented as occurring subsequent to delayed postpartum hemorrhage. It is most likely that the mechanism in this particular situation was the activation of a normal fibrinolysin by the prolonged severe hemorrhagic shock. The latter must be presumed to be the cause of death.

ORGANIZATION SECTION

Covington Surgeon Named KSMA President-Elect

Edward B. Mersch, M.D., KSMA councilor since 1948, was named president-elect of the Association on Wednesday evening, September 19, by the House of Delegates during the 1956 Annual Meeting in Louisville.



EDW. B. MERSCH
Covington

Dr. Mersch is a native of Covington and a graduate of the University of Cincinnati Medical School in the class of 1935. His undergraduate work was completed at Xavier University, Cincinnati. From 1936 to 1939 he served a surgical residency at Louisville General Hospital.

He is past president of the medical staff of St. Elizabeth Hospital, Covington, and past president of the Covington Lion's Club.

Dr. Mersch has performed able service on many KSMA committees. He is a fellow of the American College of Surgeons and a member of the Southern Medical Association, Southeastern Surgical Congress and the American Medical Association.

Karl Winter, M.D., Louisville, (Central), Carl Norfleet, M.D., Somerset (Eastern) and Charles Yancy, M.D., Hopkinsville (Western), were chosen vice-presidents of the Association.

Woodford B. Troutman, M.D., Louisville, who has been serving as secretary-pro tem since Feb. 1, 1956, was elected secretary. Dr. Troutman will fill out the two-year term of office.

Ky. Rural Health Council Plans for National Conference

"Real Kentucky hospitality" is planned for visitors to the 1957 National Conference on Rural Health, according to Wyatt Norvell, M.D., New Castle, chairman of the KSMA Committee on Rural Health and of the Kentucky Rural Health Council. The Conference will convene at the Brown Hotel in Louisville, March 7-9.

Aubrey Gates, Little Rock, Ark., AMA field director for the Rural Health Council, in speaking to the Kentucky Council at a luncheon meeting at the Brown on October 16, evaluated Conference objectives and outlined a tentative program for the March meet. Suggestions on arrangements, attendance and entertainment were offered by the Council members, who have committed their efforts toward the success of the national convention.

The importance of every Kentucky doctor of medicine lending his support to the Conference was emphasized at a meeting of the KSMA Rural Health Committee preceding the Council session. "All members are asked to urge laymen to attend and participate," said Dr. Norvell.

Dr. Norvell also presided at the Council's luncheon meeting, which was attended by 27 representatives of organizations interested in improving rural health.

Dr. Mahaffey to Head Council Dr. Toomey is Vice-Chairman

Hugh Mahaffey, M.D., Richmond, Eleventh District Councilor since 1951, was elected chairman of the KSMA Council at the annual reorganization meeting held during the recent annual assembly. He succeeds J. Vernon Pace, M.D., Paducah.



HUGH MAHAFFEY
Richmond

Dr. Mahaffey is on the staff of the Pattie A. Clay Infirmary, Richmond, and the Berea College Hospital, Berea. A graduate of the U. of L. School of Medicine in 1928, Dr. Mahaffey holds membership in the Kentucky Surgical Society and the Kentucky Chapter, American College of Surgeons. He has been active in KSMA affairs, including service on the executive committee.

L. O. Toomey, M.D., Bowling Green, Sixth District councilor, was elected vice-chairman to succeed Delmas M. Clardy, M.D. Dr. Toomey was graduated from the U. of L. School of Medicine in 1930 and is a member of the Kentucky Chapter of the American College of Chest Physicians.

Re-elected to the Council from their respective districts for three-year terms were Dr. Pace, First District; W. Keith Crume, M.D., Bardstown, Fourth; Garnett J. Sweeney, M.D., Liberty, Twelfth. Ralph Lynn, M.D., Elkton, was elected to represent the Third District, succeeding Dr. Clardy, and Charles Rutledge, M.D., Hazard, the Fourteenth, to succeed John Archer, M. D., Prestonsburg.

Five members are elected each year for a three-year term to the 15 district Council.

Woman's Auxiliary groups are being urged to see that copies of the AMA health magazine are placed in the office of every physician and dentist. This is in keeping with the 1956-57 national campaign theme of "Increased Reception Room Readership."

Honor Awards Presented to Drs. Molony and Coleman

The 1956 honor award, presented annually for distinguished service, was received by Joseph T. Molony, M.D., Covington. Honored as Kentucky's outstanding general practitioner of the year was J. T. Coleman, M.D., Frankfort. Presentations were made Sept. 20 in Louisville on the final day of the Annual Meeting.



JOSEPH T. MOLONY

Dr. Molony, twelfth recipient of the Association's service award, was recognized for his advancement in obstetrical practice in Northern Kentucky. He organized the obstetrics department at St. Elizabeth's Hospital, Covington, where he was staff president in 1941. He has been recognized several times as having delivered more babies in a year than any other doctor in the State.

A graduate of the University of Cincinnati Medical School, Dr. Molony is a founding fellow of the American College of Obstetrics and Surgery. He formerly served as a KSMA vice-president. His home is in South Hills, a Covington suburb, where he is active as a City trustee.

It was not possible for Dr. Molony to be present Thursday morning, Sept. 20, during the Annual Meeting at the time the awards were presented.

Dr. Coleman was cited for his civic and welfare activity as well as his medical practice, much of which has been of a charitable nature. Coming to Frankfort in 1913, he has delivered more than 4,500 babies during his half-century-plus of general practice. In addition, he has been active in the City's governmental affairs, having served as mayor for 16 years.

Under his leadership, Frankfort built a large housing project; bought its own light-and-water company, instituted Civil Service for City employees, and set up planning and zoning laws. Dr. Coleman has served as Franklin County coroner and as president of the Kentucky Municipal League which he helped to organize in 1929. A native of Kenton County, he was graduated in 1907 from the University of Louisville Medical School.



C. T. Coleman, M.D., Frankfort physician and civic leader, receives the KSMA 1956 Outstanding General Practitioner Award and congratulations from KSMA President R. R. Slucher, M.D., and Secretary W. B. Troutman, M.D. Presentation was made on September 20 during the Annual Meeting.

House Acts on "Medicare" Fee Schedule

Perhaps the most controversial discussion of the 1956 sessions of the House of Delegates, in the opinion of many KSMA officials, was the so-called "Medicare Program," providing for medical care for dependents of military personnel.

Late in May Public Law 569, 84th Congress, was enacted. This Act called for a federally financed program to provide medical care for "the lawful wife, children under 21, parents and parents-in-law if dependent for over half of their support, widows and the dependent children of deceased members" of service personnel.

Services included under the new law are diagnoses, care for acute medical and surgical conditions, contagious diseases, immunizations, maternity and infant care, and dental care.

A special KSMA committee was appointed by the Council to work with the AMA and the Defense Department in implementing the program in the State of Kentucky. As the law becomes effective on December 8, 1956, the Defense Department has urgently requested that the fee schedule, covering some 200 basic procedures, be presented on or before October 1.

A special committee headed by Robertson O. Joplin, M.D., Louisville, made its recommendation for this schedule and for the implementing of the program at the September 17 meeting of the Council, which in turn passed the recommendation on to the House of Delegates.

With some slight revisions, the House accepted the recommendations. A complete copy of the recommendations and the fee schedule is on file at the Headquarters office. Any member wishing to review the action of the House is welcome to do so.

Other members of the Joplin committee include Delmas M. Clardy, M.D., Hopkinsville, Thomas O. Meredith, M.D., Harrodsburg, W. Vinson Pierce, M.D., Covington, and Gaithel L. Simpson, M.D., Greenville.

Medicare Directive Signed

Defense Secretary Wilson has signed a directive to permit the dependents of servicemen to receive low-cost medical care in civilian hospitals, according to published reports as we meet our deadline.

The new law limits the service to a payment of either $25 or an amount equivalent to the subsistence charge of $1.75 per day, whichever is greater.

New Commission to Study Needs of Indigents

Russell Teague, M.D., Commissioner of Health, has been appointed chairman of a newly-appointed Commission on Indigent Care. The group will study medical and hospital needs of indigent Kentuckians and report on their findings by Sept. 1, 1957.

The KSMA will cooperate with the program, along with representatives of the Legislative Research Commission, the Departments of Economic Security, Welfare, and Health, and the State Hospital, Pharmaceutical, Dental and Nursing Association.

(Continued on Page 976)



The State Board of Health table at the KSMA President's Luncheon on September 19, included Russell E. Teague, M.D., State Health Commissioner and secretary to the Board (fourth from left facing camera), who introduced others at the table (from Dr. Teague's left, reading clockwise) Carl H. Fortune, M.D., Lexington, member; Fred S. Townsend, Ph.G., London, member; William A. Lamkin, Jr., Louisville, attorney for the board; William F. Lamb, M.D., Louisville, deputy commissioner; R. W. Robertson, M.D., Paducah, member; A. P. Markendorf, Louisville, assistant to the commissioner; John P. Godfrey, Jr., Louisville, attorney to board; Mrs. Ray Wunderlich, supervisor for medical licensure; Fred Moberly, M.D., Lexington, member; Carl J. Johnson, D. O., Louisville, member; and Thomas P. Leonard, M.D., Frankfort, vice president of the board. Not shown is E. M. Howard, M.D., Harlan, president of the board, who sat at the speaker's table with KSMA past presidents. Dr. Howard introduced Dr. Teague.

A RESEARCH MILESTONE

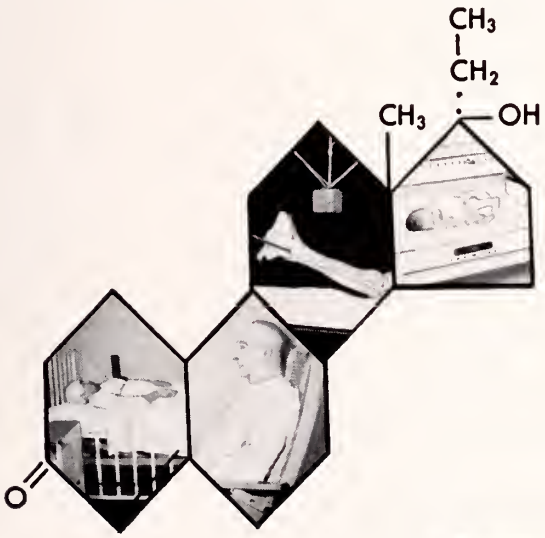
Nilevar*

(BRAND OF NORETHANDROLONE)

Searle's New and Practical Steroid Specifically for Protein Tissue Building

It has long been recognized that a substance which would promote protein anabolism would be of inestimable value in therapy. The androgens have this property, but unfortunately they also exert actions on secondary sex characteristics. These effects are commonly undesirable in therapeutic programs.

THE FIRST STEROID WITH ANABOLIC SPECIFICITY—Nilevar, the newest Searle Research development, therefore, meets a long desired clinical need because Nilevar presents the first steroid primarily anabolic for protein synthesis. Moreover, Nilevar is without prominent androgenic effects (only about one-sixteenth of that exerted by the androgens).



OBJECTIVE AND SUBJECTIVE RESPONSE—Orally effective. Nilevar therapy is characterized by retention of nitrogen, potassium, phosphorus and other electrolytes in ratios indicative of protein anabolism. Moreover, subjectively the patient observes an increase in appetite and sense of well-being.

WELL TOLERATED—Nilevar has an extremely low toxicity. Laboratory animals fail to show toxic effects after six months of continuous administration of high dosages. Nilevar should not be administered to patients with prostatic carcinoma. Nausea or edema may be encountered infrequently. Slight androgenicity may be evidenced on high dosage or in particularly responsive individuals.

MAJOR INDICATIONS—Preparation for and recovery from surgery; supportive treatment of serious illnesses (pneumonia, poliomyelitis, carcinomatosis, tuberculosis); recovery from severe trauma and burns; decubitus ulcers; care of premature infants.

DOSAGE—The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the average daily dose is 1 to 1.5 mg. per kilogram of body weight; individual dosages depend on need and response to therapy.

SUPPLY—Nilevar is available in uncoated, unscored tablets of 10 mg. G. D. Searle & Co., Research in the Service of Medicine.

*Trademark of G. D. Searle & Co.

SEARLE



William L. McGrath, Cincinnati, guest speaker at the President's Luncheon, warns that "Communism has invaded the ILO." The U.S. employer delegate to the labor conference at Geneva, Switzerland, is an Ohio heating firm executive.

McGrath, Past Presidents Share Luncheon Program

A warning of creeping "socialism" in the ILO held the rapt attention of more than 300 KSMA members and their guests at the annual president's luncheon, September 19, at the Brown Hotel.

William L. McGrath, Cincinnati heating firm president and employer delegate to the ILO at Geneva, Switzerland, spoke to the Roof Garden assembly.

Prior to the speaker's introduction, KSMA President Gant Gaither, M.D., Hopkinsville, recognized guests at the three honor tables, including Association officers, the assembly of past presidents, and members of the State Board of Health.

Changing the pace from Kentucky medical affiliations to international labor activities, McGrath charged that this year's amendments to the Social Security law—the reduction of women's retirement age from 65 to 62 and the provision for retirement benefits to disabled workers at age 50—sprang directly from proposals of the "socialistic" International Labor Organization. He called the amendments the "biggest giveaway program ever devised."

Attending the annual luncheon for the first time was representation from the new University of Kentucky School of Medicine at Lexington. William R. Willard, M.D., formerly of Syracuse, New York, who was recently appointed dean of the new school, expressed his pleasure in participating in this KSMA function.

Dr. Sparks Succeeds Dr. Vance as Speaker of the House

Clyde C. Sparks, M.D., Ashland, past KSMA president and former chairman of the Council, was elected to serve a three-year term as Speaker of the House of Delefates at the governing body's final session on September 19.



CLYDE C. SPARKS
Ashland

Dr. Sparks succeeds Charles A. Vance, M.D., Lexington, who was the second to hold the office of Speaker since the reorganization of procedure in the House of Delegates.

A fellow of the American College of Surgeons, Dr. Sparks is councilor for Kentucky for the Southeastern Surgical Congress and a member of the Kentucky Surgical Society.

George Pedigo, M.D., Louisville, succeeds E. W. Jackson, M.D., Paducah, as vice speaker. Dr. Pedigo, who is active in the Jefferson County Medical Society, has served on the KSMA committee on public information and service, and also as a member of the Board of Consultants for the Journal of the KSMA.

Dr. Aud Named Editor in New Organizational Setup

Guy Aud, M.D., Louisville, was elected editor of The Journal of the KSMA by the Council at its September 20 reorganizational meeting.

Doctor Aud, who was KSMA president in 1947, has served the past several years as chairman of the advisory committee to the editor and has been active in policy recommendations that have been made concerning The Journal.

For many years it has been traditional that the editor of The Journal and the secretary of the KSMA be the same person. However, the 1956 sessions of the House of Delegates acted favorably on recommendations from three sources calling for separation of these two offices. The bylaws were thus changed to provide that the editor of The Journal of KSMA be appointed by the Council.

Doctor Aud succeeds W. B. Troutman, M.D., Louisville, who served as secretary-editor pro tem from February 1 to the Annual Meeting. Doctor Troutman was elected following the resignation of Bruce Underwood, M.D., who was secretary and treasurer of the Association until February 1956. Dr. Troutman was elected to the new office of secretary.

New Commission to Study Needs of Indigents

(Continued from Page 974)

Included in Dr. Teague's 14-man commission are Keith Smith, M.D., Corbin, G. L. Simpson, M.D., Greenville, and Thomas P. Leonard, M.D., Frankfort. Dr. Simpson was chairman of a KSMA committee that published a study of indigent medical care in Kentucky in 1955.

Dr. Bell Succeeds Dr. Goldstein as Psychiatric Head

John Bell, M.D., Louisville, was elected president of the Kentucky Psychiatric Association at a meeting held September 19 in Louisville. He succeeds Joseph Goldstein, M.D., Louisville.

James Lowry, M.D., medical director of the U. S. Public Health Service Hospital at Lexington, was named vice-president and Logan Gragg, M.D., superintendent of Eastern State Hospital, Lexington, secretary-treasurer. E. E. Landis, M.D., Louisville, was elected as delegate to the American Psychiatric Association assembly. The KSA was organized in 1938.



Richard R. Slucher, M.D., Louisville (left), in keeping with KSMA tradition, presents retiring president Gant Gaither, M.D., Hopkinsville, with the past president's key and congratulations following the former's installation as KSMA president.

Good Attendance Recorded at Annual Meeting

Fair skies and promising program attractions drew a near-record attendance to the 1956 Annual Meeting in Louisville, September 18-20. A total of 1,885 persons registered during the three-day session, including:

Members	923
Guest Physicians	157
Guests	108
Exhibitors	218
Interns-Residents	105
Registered Nurses	15
Medical Students	305
Technicians, office assistants, etc.	54

The registered KSMA membership of 923 was near last year's record high of 938. From a total possible attendance of 1977 KSMA members, the current registration reveals that 46.7 per cent was present during the three-day gathering. This percentage is well above the national average for similar meetings.

In addition to the KSMA members meeting at the Columbia auditorium, a total of 225 registered for the Women's Auxiliary Meeting convening at the same time at the Brown Hotel. This marked an increase over last year's WA registration of 216.

Retiring President Gant Gaither expressed his pleasure at the large attendance and interest shown in program offerings.

Auxiliary Elects Officers

Mrs. Charles Stacy, Pineville, was installed as president of the Women's Auxiliary to KSMA at a post-convention board breakfast held September 20 in Louisville.

Officers elected at this meeting were: Mrs. J. Andrew Bowen, Louisville, president-elect; Mrs. William Cloyd, Richmond, Mrs. William Cartmell, Maysville, Mrs. G. B. Froage, Paducah, and Mrs. C. B. Johnson, Russell, vice presidents; Mrs. B. T. Harris, Lexington, treasurer; Mrs. J. O. Mattocks, Carrollton, recording secretary, and Mrs. Clarence Hicks, Middlesboro, corresponding secretary.

Student AMA

As a student works through his four years of medical school, he becomes the environmental product of constant contact with his faculty. He works with men after whom he must mould himself at least at first.

After the academic courses have been mostly completed, that part of our training which makes us polished physicians begins. We are truly indebted to the men in practice who donate hours of their time demonstrating how they establish friendly interest in the patient, inquire sincerely into the social aspects of the patient's life, and modify the academic regimen of therapy to comfortably comply with the patient's daily schedule.

Most of all, we must thank these men for demonstrating the importance of our education by taking added time to correct our procedures, explain our mistakes, and consider our opinions individually. These refinements in our education we accept with humility and appreciation. May we endeavor to accommodate our students as you have us.

The freshman membership drive is now nearing completion.

In addition, a general survey of the first three classes was taken to establish the need at the U. of L. Medical School for a S.A.M.A. Foundation. The survey was quite indicative of the need and there is every reason to believe that the Foundation will be established sometime this school year.

Robert G. Overstreet, President
U. of L. Chapter, Student AMA

Kentucky Surgeons Honored at ACS Clinical Congress

Daniel C. Elkin, M.D., Lancaster, was installed as president of the American College of Surgeons at the 42nd annual Clinical Congress of ACS in San Francisco, October 8-12. Dr. Elkin was formerly professor of surgery at Emory University College of Medicine, Atlanta.

R. Arnold Griswold, M.D., Louisville, was named second vice-president of the College. Dr. Griswold is also chairman of the Committee on Trauma and presided at a symposium on "The Patient With Multiple Injuries," during a Congress session on traumatic surgery.

Rudolf J. Noer, M.D., professor of surgery at the University of Louisville was featured on the program, when he led a movie symposium on new and unique problems in surgery which included demonstrations of ten unusual operations.

Approximately 10,000 surgeons from around the world attended the Congress.

Chest Disease Program Held at Paris October 24

A Postgraduate Symposium on Diseases of the Chest was held at Paris, Ky. on October 24.

This program, sponsored by District Three State Tuberculosis Hospital and the Kentucky Academy of General Practice, included scientific discussions on "X-ray Diagnosis of Chest Diseases," and phases of tuberculosis as related to public health aspects, childhood and medical management.

Two hours of Category I credit was given for attendance at the symposium.

Folsom Names Group to Work with HEW on Hospitals

In an effort to reduce hospital costs and improve care, a six-man committee has been appointed by Secretary Folsom to work with representatives of the Department of Health, Education and Welfare to study and recommend procedure in hospital management.

The study will include the organization of hospital units according to severity of illness and disability, development of units in which patients could provide more services for themselves, feasibility of using rooms for only part of one day, and ways to provide services to patients in their homes.

Russell Nelson, M.D., director of Johns Hopkins Hospital, chairman of the six-man committee, will direct the study in cooperation with Lowell T. Coggeshall, special assistant to the Secretary of Health, Education and Welfare.

15 Kentuckians Go To SMA Birthday Party

Kentuckians in attendance at the Golden Anniversary Celebration, the fifty-year birthday party, of the Southern Medical Association at Chattanooga, October 2-3, included:

Mrs. Luther Bach, Florence, past president of Southern Auxiliary; M. B. Dillon, M.D., and Mrs. Dillon, Paris; Lyman S. Hall, M.D., and Mrs. Hall, Campbellsville; C. N. Heisel, M.D., Covington, formerly member of the Council representing Kentucky;

Robert F. Monroe, M.D., Louisville, secretary of Section on Obstetrics; A. Clayton McCarty, M.D., member of the Council representing Kentucky and vice-chairman of the Council, and Mrs. McCarty, Louisville; Mrs. Arthur T. McCormack, Louisville, past president of Southern Auxiliary; John W. Scott, M.D., Lexington, former chairman of Section on Medicine;

Charles A. Vance, M.D., former chairman of Section on Surgery, and Mrs. Vance, Lexington; Roy G. Wilson, M.D., and Mrs. Wilson, Campbellsville.



Edward B. Mersch, M.D., Covington surgeon and KSMA president-elect, receives the Honor Award for Distinguished Service for Joseph T. Molony, M.D., Covington, in the latter's absence. Drs. Mersch and Molony are fellow members of the Campbell-Kenton County Medical Society. W. B. Troutman, M.D., Louisville, makes the presentation.

Big Sandy Seminar Held at Paintsville October 25

More than 100 physicians were expected to attend the Big Sandy Seminar at Paintsville on October 25. The Seminar was sponsored by the Kentucky Academy of General Practice.

The scheduled program included the following scientific presentations by University of Louisville medical professors: "Steroids in Treatment," Robert L. McClendon, M.D., Instructor in Medicine; "Digitalis and Quinidine Therapy," Ralph M. Denham, M.D., Instructor in Medicine, "Hormones—Uses and Abuses," J. B. Marshall, M.D., Assistant Professor in Obstetrics and Gynecology.

Following a banquet at 6:00 p.m., Carroll Witten, M.D., also a University of Louisville medical instructor, moderated a round-table discussion on "Therapeutic Problems in Practice," participated in by the afternoon essayists.

Eleven Specialty Groups Convene at Annual Meet

Late developments in research and practice were discussed by nationally-known guest speakers at eleven specialty group meetings held simultaneously Wednesday afternoon, Sept. 19, during the Annual Meeting.

Many of the presentations, directed to physicians who limit their practice to special fields, were emphasized by the use of visual aids.

Meeting at the Columbia Auditorium were the Kentucky Academy of General Practice, the Ky. Chapter American College of Physicians, the Ky. Chapter of the American College of Surgeons, and the Ky. Eye, Ear, Nose and Throat Society. The Kentucky Association of Public Health Physicians met at the same time at the Columbia building for business.

Next door at the First Christian Church convened Kentucky groups of the Society of Anesthesiology, the College of Chest Physicians, the American Academy of Pediatrics, the Psychiatric Association and the Radiological Society.

The Kentucky Obstetrical and Gynecologic Society and the Kentucky Orthopedic Society held their sessions across the street at the Calvary Episcopal Church.

House Revamps Committees, Considers Resolutions

A revamping of committee structure was one of the more important actions voted by the KSMA House of Delegates in the two well-attended sessions during the 1956 Annual Meeting.

Special recommendations of an authorized committee of the 1955 House were accepted, providing for fewer primary committees and more associate committees. Only primary committees would report directly to the House.

A resolution of the Perry County Medical Society, condemning an article, "The Miners' Fund, A Tribute to Good Management," appearing in the current issue of Readers Digest, was unanimously approved. The resolution stated that the article was either written without proper information or with actual intent to discredit medical care in Eastern Kentucky prior to development of the U.M.W.A. program. The resolution called for a retraction.

The House adopted a Warren County resolution changing the bylaws covering apportionment of delegates. Section 12 (Chapter XII) of the KSMA constitution formerly provided for "one delegate for each 25 members in good standing or major fraction thereof." It will now read, "one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25."

A number of recommendations made by a study committee on the constitution and bylaws were approved, including a clarification of certain existing sections and provision for minor organizational changes.

The House adopted a resolution of the Jefferson County Medical Society in which the KSMA Council was requested to consider a requirement that AMA dues from KSMA members be made mandatory, and that action on the resolution be reported to the 1957 session of the House.

Resolutions of the Jefferson and Daviess County Medical Societies, commending the new look of The Journal of the KSMA, were accepted.

Seven reference committees, instead of the usual five, were employed in handling House referrals. Officials felt the innovation contributed to the effective handling of business.

Retiring Speaker Charles A. Vance, M.D., Lexington, expressed pleasure at the deliberations of the House.

A complete digest of action at both sessions is scheduled to appear in the December Journal, along with the revised bylaws embodying changes made at the 1956 meeting.



KSMA President Gant Gaither, M.D., Hopkinsville, presided at the luncheon which honored officers, past presidents and distinguished guests, among whom was William L. McGrath (left), Cincinnati.

Military Obligations Studied as Doctor Draft Ends

The military obligation of numerous Kentucky physicians and other professionally qualified Selective Service registrants will not end with the expiration of the doctor draft next July 1, according to A. Clayton McCarty, M.D., Louisville, chairman, Advisory Committee to Selective Service.

Under Selective Service regulations physicians, as regular registrants, are liable for induction to age 35, but few are expected to be called. The Defense Department, anticipating that needs will be filled with medical school graduates, is studying basic laws to determine the deferment status of registrants for educational and occupational reasons.

Conferring with the Defense Department on procedures to meet future military needs are representatives of the American Medical Association, American Dental Association, the Association of American Medical Colleges and the four surgeons general—Army, Navy, Air Force and U. S. Public Health Service.

relaxes both the body and the mind

well suited for prolonged therapy

- well tolerated, nonaddictive, essentially nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

Indications: **anxiety and tension states, muscle spasm.**

THE ORIGINAL MEPROBAMATE

Miltown®

Tranquilizer with muscle-relaxant action

DISCOVERED AND INTRODUCED
BY WALLACE LABORATORIES, *New Brunswick, N.J.*

2-methyl-2-n-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720

SUPPLIED: *400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.*

Literature and Samples Available on Request



THE MILTOWN MOLECULE

CM 3706 R

KSMA Represented on SMA Med. Student Program

Two KSMA representatives will participate in a special dinner meeting program sponsored by the Southern Medical Association for the representatives of senior classes from nine medical schools in and near Washington, D. C., the evening of November 12, at the Sheraton-Park Hotel.

"Where Does the Southern Medical Association Come In," will be discussed by A. Clayton McCarty, M.D., Louisville, Councilor for Kentucky and chairman of the SMA Council. "The Physician and His State Medical Society" is the subject of a brief talk by KSMA Executive Secretary J. P. Sanford, Louisville.

George F. Lull, M.D., secretary and general manager of the American Medical Association, Chicago, will also take part in the above meeting. The senior medical students will be guests of the SMA from November 10 through 15, according to V. O. Foster, SMA executive secretary. Guided tours, special programs and attendances at SMA functions will highlight the students' visit, Mr. Foster said.

Sister Agnes Miriam Elected President of KSARN

The newly elected president of the Kentucky State Association of Registered Nurses is Sister Agnes Miriam, director of the department of nursing of Nazareth College, Louisville. She succeeds Joy McCuddy, Lexington.

Lola Bell Akin, Paintsville public health nurse, was elected second vice-president. Sister Mary Evarista, Covington, has a year remaining to serve of her two-year term as first vice-president. Elsie Pearson, director of home-nursing service for the Red Cross at Louisville was re-elected treasurer. Elections took place on October 12 at Paducah.



"I shall champion the cause of freedom in medical practice . . . " repeats Richard R. Slucher, M.D. (right) in taking the KSMA presidential oath of office from J. Vernon Pace, M.D., Paducah, chairman of the KSMA Council. Dr. Slucher's inaugural ceremony took place Thursday morning, Sept. 20, during the closing general session.

President Appoints 37 Committees for 1956-57

The 1956-57 committees appointed by the KSMA president have been announced by Richard R. Slucher, M.D., Louisville.

As indicated in another part of this issue, the committee structure of KSMA was revised by action of the 1956 House of Delegates.

Dr. Slucher expressed himself as being in favor of the changes, believing they would contribute to more effective operation of the Association.

Committees appointed by the Council and the House of Delegates will be carried in another issue of The Journal.

Presidential appointments are:

Committee on Scientific Assembly and Arranagements

Richard R. Slucher, M.D., Louisville, Chairman
Edward B. Mersch, M.D., Covington, Vice Chairman
Rudolf J. Noer, M.D., Louisville
(term expires 1957)
Charles C. Rutledge, M.D., Hazard
(term expires 1958)
Frank L. Duncan, M.D., Monticello
(term expires 1959)

Associate Committee on KSMA Golf Association

Robert C. Long, M.D., Louisville, Chairman
Clifton G. Follis, M.D., Glasgow
Kenton D. Leatherman, M.D., Louisville
Robert E. Reichert, M.D., Covington
William C. Wolfe, M.D., Louisville

Associate Committee on Post-Graduate Medical Education

Garnett J. Sweeney, M.D., Liberty, Chairman
Harry S. Andrews, M.D., Louisville
Walter S. Coe, M.D., Louisville
Allen L. Cornish, M.D., Lexington
Joseph E. Hamilton, M.D., Louisville
Robert Lich, Jr., M.D., Louisville
Rogers L. Queen, Jr., M.D., Okolona
John C. Quertermous, M.D., Murray

Associate Committee on Scientific Exhibits

Everett L. Pirkey, M.D., Louisville, Chairman
William P. Humphrey, M.D., Sturgis
Arthur F. Schultz, M.D., Newport
Melvin Shein, M.D., Louisville
Paul J. Sides, M.D., Lancaster

Associate Committee on Technical Exhibits

W. O. Johnson, M.D., Louisville, Chairman
A. B. Colley, M.D., Owensboro
Glenn U. Dorroh, M.D. Lexington
Jesse T. Funk, M.D., Bowling Green
Willard A. Litzenberger, M.D., Elizabethtown

Committee on Emergency Medical Service

Theodore L. Adams, M.D., Lexington, Chairman
L. L. Cull, M.D., Frankfort
Francis J. Halcomb, M.D., Scottsville

W. D. Haley, M.D., Paducah
Stuart M. Hunter, M.D., Louisville
Otto H. Salsbery, M.D., Covington
P. J. Winn, M.D., Ashland
Charles F. Wood, M.D., Louisville

Committee to Study Relotions with Voluntary Heolth Groups

Carlisle Morse, M.D., Louisville, Chairman
O. Leon Higdon, M.D., Paducah
David M. Cox, M.D., Louisville
Carl H. Fortune, M.D., Lexington
Hugh L. Houston, M.D., Murray
Richard R. Slucher, M.D., Louisville
C. C. Sparks, M.D., Ashland
Charles F. Wood, M.D., Louisville

McDowell Home Committee

Charles A. Vance, M.D., Lexington, Chairman
Laman A. Gray, M.D., Louisville
O. Leon Higdon, M.D., Paducah
E. M. Howard, M.D., Harlan
Richard G. Jackson, M.D., Danville
Norman T. E. Shepherd, M.D., Hopkinsville
Robert Russell Starr, M.D., Glasgow

Committee on Rurol Heolth

Wyatt Norvell, M.D. New Castle, Chairman
7th District
Joseph R. Miller, M.D., Benton
1st District
Walter L. O'Nan, M.D., Henderson
2nd District
Ralph D. Lynn, M.D., Elkton
3rd District
Dixie E. Snider, M.D., Springfield
4th District
Everett N. Rush, M.D., Fern Creek
5th District
Daryl P. Harvey, M.D., Glasgow
6th District
Wilbur R. Houston, M.D., Erlanger
8th District
Mitchell B. Denham, M.D., Maysville
9th District
James S. Williams, M.D., Nicholasville
10th District
Donald L. Graves, M.D., Frenchburg
11th District
Frank L. Duncan, M.D., Monticello
12th District
George P. Carter, M.D., Louisa
13th District
Carl Pigman, M.D., Whitesburg
14th District
Cecil W. Ely, M.D., Manchester
15th District

Committee on Labor-Manogement Health Plons

Clyde C. Sparks M.D., Ashland, Chairman
J. Duffy Hancock, M.D., Louisville, Vice-Chair
Howell J. Davis, M.D., Owensboro
Carl H. Fortune, M.D., Lexington
G. Y. Graves, M.D., Bowling Green
Eugene H. Kremer, M.D., Louisville
W. Vinson Pierce, M.D., Covington

Associote Advisory Committee to UMWA

Carl H. Fortune, M.D., Lexington, Chairman
George P. Archer, M.D., Prestonsburg
W. Clark Bailey, M.D., Harlan
George F. Brockman, M.D., Greenville
Walter Coe, M.D., Louisville
W. C. Hambley, M.D., Pikeville
C. D. Snyder, M.D., Hazard
Loman C. Trover, M.D., Madisonville

Advisory Committee to Womon's Auxiliory

Keith P. Smith, M.D., Corbin, Chairman
Rankin C. Blount, M.D., Lexington
R. Ward Bushart, M.D., Fulton

Committee on Medicol Services

W. Irvin Abell, Jr., M.D., Louisville, Chairman
Everett H. Sanneman, Jr. M.D., Louisville
C. Melvin Bernhard, M.D., Louisville
Orville R. Miller, M.D., Louisville
K. Armand Fischer, M.D., Louisville
Carlisle Morse, M.D., Louisville
Maurice Kaufman, M.D., Lexington
Edgar B. Morgan M.D., Louisville
W. Reeve Hansen, M.D., Louisville
Ernest A. Terry, Jr., M.D., Louisville
Edwin P. Solomon, Jr., M.D., Louisville
Louis M. Foltz, M.D., Louisville
Owen S. Ogden, M.D., Louisville
Rex O. McMorris, M.D., Louisville
Joseph H. Humpert, M.D., Covington

Associote Committee on Blood Bonks

Everett H. Sanneman, Jr., M.D. Louisville, Chair
Samuel M. Adams, M.D., London
H. C. Burkhart, M.D., Harlan
Hubert C. Jones, M.D., Berea
David Y. Keith, M.D., Paducah
Elmer S. Maxwell, M.D., Lexington
William T. McElhinney, M.D., Covington
Harold N. Parker, M.D., Maysville

Associote Committee on Concer

C. Melvin Bernhard, M.D., Louisville, Chairman
Russell H. Davis, M.D., Pikeville
John L. Dixon, M.D., Owensboro
John B. Floyd, M.D., Lexington
Jesshill Love, M.D., Louisville
J. Albert Vesper, Jr., M.D., Covington

Associote Committee on Cerebrol Palsy

Orville R. Miller, Sr., M.D., Louisville, Chair
Irving A. Gail, M.D., Lexington
Richard F. Grise, M.D., Bowling Green
Julian R. Hardaway, M.D., Danville
V. F. Voss, M.D., Louisville

Associote Committee on Crippled Children

K. Armand Fischer, M.D., Louisville, Chairman
James M. Riley, M.D., Louisville
Ruel T. Routt, M.D., Sonora
Horace E. Titsworth, M.D., Clinton
Thomas D. Yocum, M.D., Lexington

Associate Committee on Diabetes

Carlisle Morse, M.D., Louisville, Chairman
Herald K. Bailey, M.D., Ashland
George Philip Carter, M.D., Louisa
Marcus A. Coyle, M.D., Springfield
Thomas J. Crume, M.D., Owensboro
Robert J. Hoffman, M.D., Fort Mitchell
Elmo K. Hughes, M.D., Pleasure Ridge
Albert H. Joslin, M.D., Beaver Dam

Franklin B. Moosnick, M.D., Lexington
Stanley T. Simmons, M.D., Louisville

Associate Committee on Diatetics

Maurice Kaufmann, M.D., Lexington, Chairman
William E. Becknell, M.D., Manchester
John E. Bickel, M.D., Owensboro
Eugene M. Holmes, M.D., Louisville
W. E. Hoy, M.D., Ashland

Associate Committee on General Practice

Edgar B. Morgan, M.D., Louisville, Chairman
C. Walker Air, M.D., Ludlow.
R. E. Davis, M.D., Central City
Wilbur R. Houston, M.D., Erlanger
Homer B. Martin, M.D., Louisville
Willett H. Rush, M.D., Frankfort
Robert L. Sumner, M.D., Henderson

Associate Committee on Geriatrics and Long Term Illness

W. Reeve Hansen, M.D., Louisville, Chairman
Thomas T. Brackin, Jr., M.D., Bardwell
Burl Mack, M.D., Pewee Valley
David G. Miller, Jr., M.D., Morgantown
Earl P. Oliver, M.D., Scottsville
Barton L. Ramsey, M.D., Somerset
Sam D. Taylor, M.D., Henderson

Associate Committee on Industrial Medicine and Surgery

Ernest A. Terry Jr., M.D., Louisville, Chairman
W. Vernon Lee, M.D., Covington
J. E. Moore, M.D., Ashland
George B. Sanders, M.D., Louisville
Burton A. Washburn, M.D., Paducah
Grady Rountree, M.D., Louisville
Charles Stacy, M.D., Pineville

Associate Committee on Infant and Maternal Mortality

Edwin P. Solomon, Jr., M.D., Louisville, Chairn
Robert C. Bateman, M.D., Danville
O. H. Fearing, M.D., Ashland
Robert J. Griffin, M.D., Lexington
Margaret A. Limper, M.D., Louisville
Robert N. McLeod, Jr., M.D., Somerset
Robert F. Monroe, M.D., Louisville
W. H. Parker, M.D., Owensboro
James A. Ward, M.D., Paducah

Associate Committee on Mental Hygiene and Mental Institutions

Louis M. Foltz, M.D., Louisville, Chairman
Irving A. Gail, M.D., Lexington
Hollis Johnson, Jr., M.D., Louisville
A. M. Lyon, M.D., Ashland
Robert C. Smith, M.D., Newport

Associate Committee on Pediatrics

Owen S. Ogden, M.D., Louisville, Chairman
Lenore P. Chipman, M.D., Williamstown
Guy C. Cunningham, M.D., Ashland
J. G. VanDermark, M.D., Covington
J. E. Dunn, M.D., Paducah
Daniel B. McIlvoy, Jr., M.D., Bowling Green
F. Hays Threlkel, M.D., Owensboro

Associate Committee on Physical Therapy

Rex O. McMorris, M.D., Louisville, Chairman
Richard T. Hudson, M.D., Louisville
Kenton D. Leatherman, M.D., Louisville

MONODRAL® WITH MEBARAL®



ANTICHOLINERGIC • SEDATIVE

in peptic ulcer management

- relieves pain promptly
- reduces tension safely
- tranquilizes without dulling
- well tolerated
- promotes healing
- maintains anacidity for hours
- controls hyperactivity of upper gastro-intestinal tract

MONODRAL with MEBARAL—the "psychovisceral stabilizer"—provides for patients with ulcer and gastro-intestinal spasm an effective barrier against the impact of environmental stimuli . . . controls gastric hypersecretion and hypermotility for three and one half to five hours.*

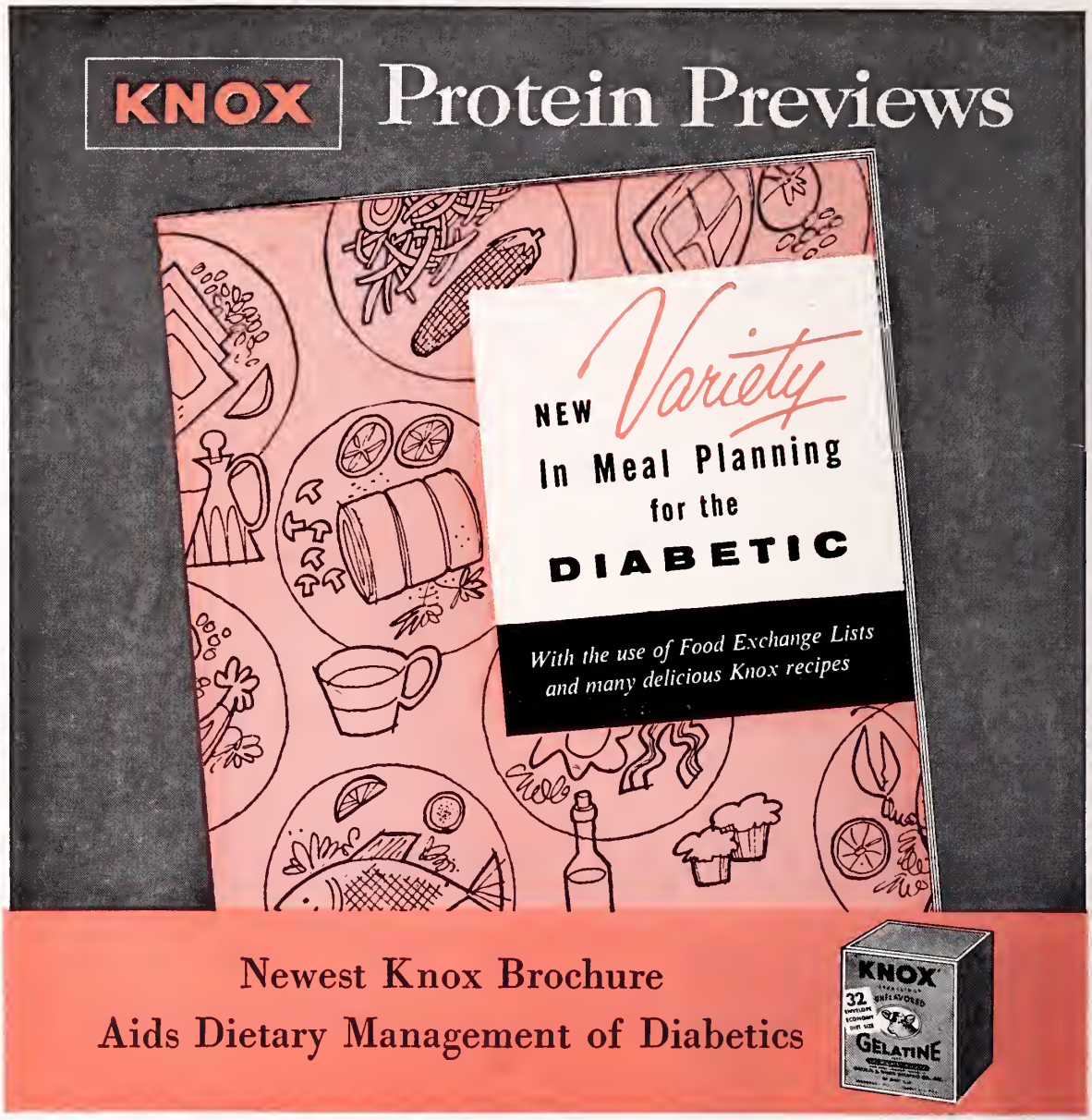
EACH TABLET CONTAINS:
MONODRAL bromide..... 5 mg.
MEBARAL.....32 mg.

DOSAGE: 1 or 2 tablets three or four times daily.
Available on prescription only.
Bottles of 100 tablets.

Winthrop Laboratories New York 18, N. Y.

Monodral (brand of penthienate) and Mebaral (brand of mephobarbital), trademarks reg. U. S. Pat. Off.
References and clinical trial supplies available on request.

KNOX Protein Previews



Newest Knox Brochure Aids Dietary Management of Diabetics

Although more than 50% of diabetics can be managed with proper diet, continued success is dependent upon proper motivation of patients. Determination to abide by dietary restrictions is also important for the diabetic being managed with insulin.

The new Knox booklet "New Variety in Meal Planning" has been prepared to help the physician enlist the patient's enthusiasm for dietary measures and to help maintain this enthusiasm. It explains the importance of diet to the diabetic, shows him how to use the newest dietary advance —Food Exchange Lists[1]—and then describes how to provide tasty variety with 14 pages of tested, diabetic recipes.

"New Variety in Meal Planning" makes no attempt to prescribe a system of treatment. It shows how the recipes described may be used to good advantage in practically any system of diabetic management. If you would like a supply for your practice, use coupon below.

1. Developed by the U. S. Public Health Service assisted by committees of The American Diabetic Association, Inc. and The American Dietetic Association.

Knox Gelatine Company
Professional Service Department SJ-20
Johnstown, N. Y.

Please send me.....copies of the new Knox diabetic brochure describing the use of Food Exchange Lists.

YOUR NAME AND ADDRESS

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

Available

Tax Returns
Bookkeeping
Delinquent Accounts
(No Commission)
Office Routines
Office Planning
Instructing Personnel
Fees
Partnerships
Hospitals
Clinics
Counselling - Investments
Insurance

ASSOCIATES:

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hubert G. Stiffler
Daniel L. Zeiser
Richard J. Conklin

PROFESSIONAL BUSINESS MANAGEMENT

FOR DOCTORS ONLY

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945
WOodburn 1-1010

141 West McMillan Street
Cincinnati 19, Ohio

I would like to talk with one of your Kentucky representatives.

Name.....

Address.....

.....Telephone.....

All Services Completely Confidential

Henry H. Moody, M.D., Cynthiana
William C. Roland, M.D., Pikeville

Associate Committee on Tuberculosis

Joseph H. Humpert, M.D., Covington, Chairman
J. Ray Bryant, M.D., Louisville
Raymond C. Comstock, M.D., Louisville
Hugh L. Houston, M.D., Murray
Max D. Klein, M.D., Shelbyville
Richard E. Mardis, M.D., Louisville
John G. Samuels, M.D., Hickman

Committee on Allied Professions

John S. Llewellyn, M.D., Louisville, Chairman
Sam A. Overstreet, M.D., Louisville
Charles G. Bryant, M.D., Louisville
Samuel H. Flowers, M.D., Middlesboro
Robert E. Pennington, M.D., London
Michael R. Cronen, M.D., Louisville
C. C. Howard, M.D., Glasgow
John D. Handley, M.D., Hodgenville

Associate Advisory Committee to Blue Cross

Sam A. Overstreet, M.D., Louisville, Chairman
John C. Baker, M.D., Berea
Rankin C. Blount, M.D., Lexington
William H. Cartmell, M.D., Maysville
Willard M. Buttermore, M.D., Harlan
Lloyd M. Hall, M.D., Salyersville
O. Leon Higdon, M.D., Paducah
James E. Hix, M.D., Owensboro
Wilbur R. Houston, M.D., Erlanger
Arthur M. Jester, M.D., Danville
Max P. Jones, M.D., Louisville
Thomas P. Leonard, M.D., Frankfort
W. R. McCormack, M.D., Bowling Green
Gabe A. Payne, Jr., M.D., Hopkinsville
John J. Sonne, M.D., Bardstown
Leslie H. Winans, M.D., Ashland

Associate KSMA Dental Committee

Charles G. Bryant, M.D., Louisville, Chairman
William J. Martin, Jr., M.D., Louisville
James S. Rich, M.D., Lexington
Paul J. Sides, M.D., Lancaster
Roy G. Wilson, M.D., Campbellsville

Associate Committee on Hospitals

Samuel H. Flowers, M.D., Middlesboro, Chairm
W. B. Atkinson, M.D., Campbellsville
Robert R. Burnam, M.D., Louisville
Preston T. Higgins, M.D., Hopkinsville
H. E. Martin, M.D., Ashland
Augustus J. Pauli, M.D., Louisville

Associate Committee on Nurse Training

Robert E. Pennington, M.D., London, Chairman
Henry B. Asman, M.D., Louisville
Byron Bizot, M.D., Louisville
Melvin E. Dean, M.D., Lexington
Chrisman S. Jackson, M.D., Danville
J. E. McKinney, M.D., Maysville

Associate KSMA Pharmacy Committee

Michael R. Cronen, M.D., Louisville, Chairman
George O. Nell, M.D., Columbia
Frank K. Sewell, M.D., Mt. Sterling
Stanley E. Smith, M.D., Louisville
H. G. Wells, M.D., Georgetown

Associate Advisory Committee on Public Health

C. C. Howard, M.D., Glasgow, Chairman
J. M. Dishman, M.D., Greensburg
C. Howe Eller, M.D., Louisville
Shelby L. Hicks, M.D., New Castle
L. A. Wahle, M.D., Shelbyville
J. C. Woodall, M.D., Trenton

Associate Committee on School Health

John D. Handley, M.D., Hodgenville, Chairman — 4th District
Conrad H. Jones, M.D., Murray — 1st District
Walter L. O'Nan, M.D., Henderson — 2nd District
Hylan H. Woodson, M.D., Greenville — 3rd District
Carroll L. Witten, M.D., Louisville — 5th District
Daryl F. Harvey, M.D., Glasgow — 6th District
Wyatt Norvell, M.D., New Castle — 7th District
Wilbur R. Houston, M.D., Erlanger — 8th District
Benjamin F. Allen, M.D., Flemingsburg — 9th District
James S. Williams, M.D., Nicholasville — 10th District
Vernon O. Kash, M.D., Winchester — 11th District
McLeod Patterson, M.D., Somerset — 12th District
John F. Green, M.D., Sandy Hook — 13th District
Carl Pigman, M.D., Whitesburg — 14th District
Boyce E. Jones, M.D., London — 15th District
Henry Wilbur, D.D.S., Louisville — Dentist

KSMA Representative to Conference of Presidents and Other Officers of State Medical Association

G. Y. Graves, M.D., Bowling Green

KSMA Representatives on Joint Commission for Improvement of Patient Care

Arthur T. Hurst, M.D., Louisville, Chairman
Winfrey P. Blackburn, M.D., Frankfort
Daniel G. Costigan, M.D., Louisville
Samuel H. Flowers, M.D., Middlesboro
George H. Rodman, M.D., Greenville

KSMA Adviser to University of Louisville Student AMA Chapter

Lawrence T. Minish, Jr., M.D., Louisville

Senior Day Committee

Richard G. Elliott, M.D., Lexington, Chairman
John S. Harter, M.D., Louisville
Robertson O. Joplin, M.D., Louisville
J. Murray Kinsman, M.D., Louisville
Lawrence T. Minish, Jr., M.D., Louisville



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Member of the American Hospital Association and National Association of Private Psychiatric Hospitals

Four modern buildings, separate for men and women Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD,
Hospital Administrator

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M.D., Neuropsychiatrist
Medical Director

T. J. SMITH, M.D., Associate

Ford Foundation Grants U. L. Med. School $500,000

The University of Louisville School of Medicine has been selected by the Ford Foundation to receive a grant of $500,000.

This was one of 43 equal grants made by the Foundation to privately supported four-year medical schools. The sum is to be invested for at least ten years during which time the interest may be used for other than construction purposes. After ten years both the principal and the interest may be used for any purpose as needed.

Other annual income now being received by the University of Louisville School of Medicine includes $500,000 from the State and $125,000 from the City of Louisville.

Chest Ills Program Nov. 29 at Ashland

The Sixth Monthly Symposium on "Diseases of the Chest" will be held at the District Four TB Hospital, Ashland, on November 29. The scientific program follows:

7:00—7:30 P.M. "Epidemiology of Tuberculosis," Donald P. Conwell, M.D., director, bureau of preventive medicine, State Department of Health

7:30—8:00 P.M. "Childhood Tuberculosis," Leonard T. Davidson, M.D., former chief, Children's Hospital, Louisville

8:00—8:30 P.M. "Major Pathogenic Fungi Diagnosis and Therapy," Daniel N. Pickar, M.D., asst. chief of medicine and chief of section on chest diseases, VA Hospital, asst. professor of medicine, U. of L., Louisville

8:30—9:00 P.M. "Diagnosis of Carcinoma of the Lung," William C. Hambley, M.D., thoracic surgeon, Pikeville

UK Dean Visits 1st District

William R. Willard, M.D., dean of the University of Kentucky School of Medicine, Lexington, was guest speaker at a dinner meeting of the First Councilor District on October 24, according to J. Vernon Pace, M.D., Paducah.

Dr. Willard spoke on "Kentucky's New Medical Center and the Medical Profession." The McCracken County Medical Society was host to the meeting which was held at the Ritz Hotel, Paducah.

Unit on Alcoholism Formed

L. M. Foltz, M.D., Louisville psychiatrist, has been named chairman of the newly-formed Commission for Study and Treatment of Alcoholism in Kentucky. Gradie R. Rowntree, M.D., Louisville, vice-chairman, is another member of the seven-man Commission.

According to Dr. Foltz, the Commission has held two planning meetings for future operations. "The Legislature did not appropriate funds for the program," he said, "and we will try to find private sources to implement it temporarily. One of our goals is to find more hospital beds for the treatment of alcoholics. Also, we plan to study the programs of other states and to work with Alcoholics Anonymous and other groups interested in the problem."

Meet Honors Dr. Henderson

Mrs. Elmer Lee Henderson, A. Clayton McCarty, M.D., and Mrs. McCarty all of Louisville, were in Havana, Cuba, October 9 for the SMA official luncheon honoring the late Elmer Lee Henderson, M.D. Dr. Henderson was president of the Southern Medical Association in 1947, the American Medical Association in 1950 and the World Medical Association in 1950.

Dr. McCarty spoke on "Dr. Elmer Lee Henderson and the Southern Medical Association." The meeting was held in connection with the World Medical Association at the Hotel Nacional de Cuba.

Ky. Foundation Directors

Clyde C. Sparks, M.D., Ashland, and Branham B. Baughman, M.D., Frankfort, have been named among nine new directors to the Kentucky Medical Foundation. Dr. Sparks formerly served as president of the KSMA and speaker of the House of Delegates, and Dr. Baughman was formerly chairman of the KSMA Council.

Federal Funds Finance Study

According to an announcement by Russell E. Teague, M.D., Louisville, State Health Commissioner, federal grants have made it possible for eleven Kentucky public health workers to continue their professional study at out-of-state universities.

Included in this group are Edwin West, M.D., Bureau of Local Health Services, at Johns Hopkins University at Baltimore, and Judith Stout, M.D., Hardin-Meade-Breckinridge County health officer, at the University of North Carolina, Chapel Hill.

Florida Has New Headquarters

The 82-year-old Florida Medical Association dedicated its new headquarters office on September 15 at Jacksonville. The Riverside Avenue building cost more than $100,000.

Calling it the "workshop of the 3,000 members" of the Florida Medical Association, President Francis H. Langley, M.D., cut the ribbon signalling the official opening of the headquarters and dedicated it to the Association's use as a "market place of professional ideas."



Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

C I B A
Summit, N. J.

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

2/22284

U. K. Staff Adds Physicians

Four professors have recently been added to the staff of the University of Kentucky School of Medicine as follows:

Richardson Noback, M.D., assistant dean and associate professor of medicine; Howard Bost, M.D., medical economist; Robert Straus, M.D., medical sociologist; and Alan Ross, M.D., medical statistician. All are from the State University of New York College of Medicine at Syracuse.

Hopkins Plan Approved

A one million-dollar building expansion plan for the Hopkins County Hospital has been approved by the Madisonville City Council. The project will be financed by revenue bonds amounting to $300,000, to be issued through a holding company, plus $250,000 contributed in hospital fund drives to match federal funds available under the Hill-Burton Act.

Dr. Cartmell is on Legal Unit

W. H. Cartmell, M.D., Maysville, has been selected to represent the Morehead State College Board of Regents as a member of the Kentucky Council on Public Higher Education. A legal agency, the Council is responsible for coordinating higher education in the Commonwealth.

Hawesville Plans Med. Center

Articles of Incorporation have been filed with the State Department at Frankfort to establish a Hancock County Medical Center at Hawesville. The 40 by 70 ft. center will include reception rooms, offices, a laboratory, patient examination, X-ray, emergency and delivery rooms.

Get Immunizations Brochure

KSMA members interested in immunizations information for international travel should write the Public Health Service of the U. S. Department of Health, Education and Welfare, Washington, D.C., for the special brochure just published.

A copy of the information is on file in the KSMA Headquarters office at 620 South Third Street, Louisville.

Dr. Webb Feted at Livingston

R. G. Webb, M.D., general practitioner for 50 years in Rockcastle County, was honored by his many friends on September 30 at a "Doctor Webb Day."

Following a parade through downtown Livingston, several speakers lauded Doctor Webb's half-century of service to the local community, including his civic and economic leadership as well as his medical practice. Doctor Webb has delivered more than 1,500 babies in Rockcastle County.

Ky. PPS Offers New Service to MS's and Communities

In this issue of The Journal of the Kentucky State Medical Association a new service to physicians and communities is being inaugurated, the Kentucky Physicians' Placement Service. This department will be carried as often as listings of communities give a need for physicians and physicians list a desire for locations.

Communities listed have been approved either by the County Society secretary or by the district councilor. This department will be found on Page ??

News Items

CORRECTION

The Journal regrets the incorrect listing of the current status of William Pingelton, M.D., Louisville, which inadvertently appeared in a previous issue. Instead of having begun a practice, Dr. Pingelton is serving a residency at the Louisville General Hospital.

John P. Bell M.D., Harvey R. St. Clair, M.D., and Sandor Klein, Ph.D., have announced the association of Hollis Johnson, M.D., and the removal of their offices from the Heyburn to the Fincastle Building in Louisville.

E. Franklin Hall, M.D., Ashland, is the new medical director in Greenup and Boyd counties. Dr. Hall entered public health in January 1955 after engaging in general practice several years. A native of Flemingsburg, he is a graduate of the University of Louisville School of Medicine. His internship was served at the Good Samaritan Hospital in Cincinnati.

Lawrie E. Jordan, M.D., is now in the practice of general medicine at Earlington. Dr. Jordan, a graduate of the Northwestern University Medical School in 1944, was formerly located at Henderson. He is associated with the Trover Clinic at Madisonville.

J. C. McGuire, M.D., Greenville, has accepted a position in the Division of Local Health Services of the State Department of Health. Dr. McGuire was graduated from the University of Louisville School of Medicine in 1928.

Alvin Poweleit, M.D., and Mrs. Poweleit, Covington, are recovering from injuries suffered in an automobile accident while en route to Louisville to attend the KSMA Annual Meeting in September. They were treated at St. Elizabeth's Hospital, Covington.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 5, 6, 7 and 8, 1957

PALMER HOUSE, CHICAGO

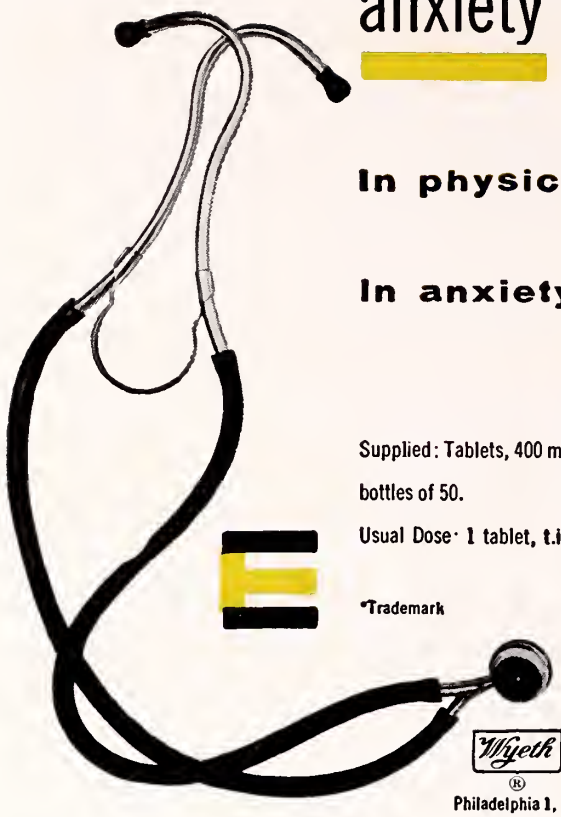
Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist.

Panels on Timely Topics — Daily Teaching Demonstrations

Medical Color Telecasts

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.



anxiety is part of every illness

In physical sickness...

anxiety

In anxiety...

Equanil®

Supplied: Tablets, 400 mg., bottles of 50.

Usual Dose: 1 tablet, t.i.d.

*Trademark

MEPROBAMATE

(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

Licensed under U.S.Patent No. 2,724,720

Wyeth®

Philadelphia 1, Pa.

anti-anxiety factor with muscle-relaxing action

PERTINENT PARAGRAPHS

The 1956 Honor Awards for Distinguished Service in Medical Journalism were presented to the JOURNALS OF THE MEDICAL ASSOCIATION OF GEORGIA, published by the Medical Association of Georgia, Edgar Woody, Jr., M.D., editor; THE MEDICAL CLINICS OF NORTH AMERICA, a bimonthly of the W. S. Saunders Co., Philadelphia, Dwight J. Hotchkiss, B. A., editor; BROOME COUNTY MEDICINE, published monthly by the Broome County Medical Society, Binghampton, N. Y., John Sargent, editor and executive secretary. Presentations were made at the Annual Meeting of the American Medical Writers' Association in Chicago on Sept. 28.

Reporters and photographers were recently invited for the first time to attend hearings of the Texas State Board of Medical Examiners on complaints against doctors. The decision to take the public into its confidence and thus provide better medical care, according to Howard O. Smith, M.D., Marlin, Texas, was prompted by programs of the Texas Medical Association and its affiliate, the Texas Academy of General Practice.

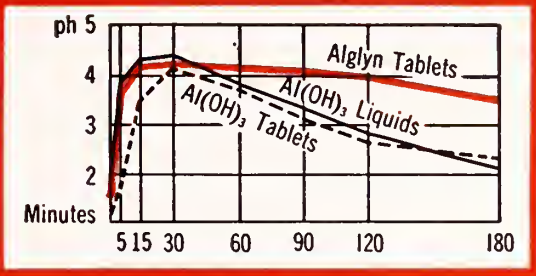
A 30-minute film, "Doctor, Take the Stand," will be premiered November 27 at the AMA Clinical Session in Seattle. This is the first in a series of motion pictures on "Medicine and the Law" produced for the American Medical Association by the Wm. S. Merrell Co., Cincinnati pharmaceutical house. Prints of the movie will be available to medical groups after December 15.

The new radio transcription series of the AMA features a 13 program "hit parade," tracing medical progress in five-year intervals through popular songs and medical features beginning with 1895 and continuing to the present.

National Pharmacy Week was observed over the nation, October 7-13. The theme of its recognition was "Your Pharmacist Works for Better Community Health." Approximately 110,000 pharmacists are registered in the U. S.

Worthy premedical students at the University of Kentucky have access to living quarters in a house at 112 Maxwell Street, Lexington, made available by Lexington doctors as a means of furthering medical education. U. K. President Frank G. Dickey states that 15 students can be accommodated and that management of the building will be the responsibility of the University while the title will remain with the medical group.

Announcing Revision of N.N.R. Monograph for



ALGLYN®

dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent in vivo studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayton PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

In Memoriam

RICHARD ALEXANDER BATE, SR., M.D.
Louisville
1871-1956

Dr. Bate, 85, died October 6 at his home in Louisville. One of the first endocrinologists in the U.S., he began his 61-year medical career as a general practitioner, then specialized in internal medicine.

A native of Smithfield, Dr. Bate was graduated from the Louisville Hospital College of Medicine in 1892. He served at various times on the faculties of the Hospital College of Medicine, the old medical department at the University of Kentucky, and the U. of L. Medical School.

BENJAMIN F. AYDELOTTE, M.D.
Louisville
1898-1956

A Louisville physician of many years, Dr. Aydelotte died September 30 at his home. He was 57.

A native of Newtown, Ind., Dr. Aydelotte was graduated from the U. of L. School of Medicine in 1933 and later served as a medical officer in World War II in the North African and Italian campaigns. He was a member of the staffs of St. Joseph Infirmary and Kentucky Baptist Hospital.

MALLORY L. SMITH, M.D.
Maceo
1883-1956

Following a brief illness, Dr. Smith 72, died on September 22 in the Owensboro-Daviess County Hospital.

A graduate of the University of Tennessee Medical School, Dr. Smith served his internship at the Memphis Baptist Hospital. He practiced in Pierce, Tenn., and in Fulton, Ky., before coming to Maceo and establishing a practice in 1922.

JOHN W. HEIM
Louisville
1881-1956

Dr. Heim, 75, physician and anesthesiologist, died September 25 at the Kentucky Baptist Hospital.

A specialist in anesthesiology, Dr. Heim was credited with designing a mouthpiece for the administration of continual anesthetics to a patient with the mouth open, and was recognized as the first anesthesiologist in Louisville providing for prolonged anesthesia for major surgery.

Dr. Heim was a member of the staffs of the Baptist, SS Mary and Elizabeth, St. Anthony, Jewish and Children's hospitals. He was graduated from the University of Louisville Medical College in 1904.

Relax the best way
... pause for Coke



continuous quality
is quality you trust

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

WAYSIDE HOSPITAL

168 North Broadway
Lexington, Kentucky

A private psychiatric hospital for men, offering modern diagnostic and treatment procedures, a luxurious club-like atmosphere, and a cordial hospitality.

APPROVED BY AMERICAN MEDICAL ASSOCIATION

STAFF

H. HALBERT LEET, M.D. — JOHN H. ROMPF, M.D.
CARL WIESEL, M.D. — IRVING A. GAIL, M.D.
EDWARD L. HOUCHIN, ADMINISTRATOR

Phone: 2-2050

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)
(The Pioneer Postgraduate Medical Institution in America)

EYE, EAR, NOSE AND THROAT

A three months cambined full time refresher course consisting of attendonce ot clinics, witnessing aperatians, lectures, demonstratians af coses ond cadaver demonstrotions; operative eye, eor, nose ond thraot an the cadaver; clinicol and codover demanstrotions in bronchoscapy, loryngeol surgery and surgery for fociol palsy; refroction; radiolagy; pothology, bocteriolagy and embryolagy; physiology; neura-onotomy; onesthesiolagy; physical medicine; ollergy, as opplied to clinicol practice. Examinotion af patients preoperatively and follow-up postaperatively in the words and clinics. Attendance at departmentol ond generol conferences.

PRACTICAL ELECTROCARDIOGRAPHY

A two weeks port time elementory course far the proctitioner based upan an understonding af electrophysiologic principles. Stondard, unipalar and precardial electracordiagrophy of the narmal heort. Bundle branch black, ventriculor hypertraphy, ond myocardial infarctian cansidered from clinical as well as electrocordiogrophic viewpoints. Diognasis of arrhythmias af clinicol significonce will be emphosized. Attendonce at, and participatian in sessians af actual reading of routine haspital electracardiagrams.

For Information about these and other courses Address:

THE DEAN, 345 WEST 50th St., New York 19, N. Y.

IN MEMORIAM (Cont.)

JACK GRAHAM WEBB

Lexington

1916-1956

A Lexington surgeon, Dr. Webb, 40, died October 7. He was a native of Virginia and was educated at the University of Richmond and the Medical College of Virginia.

Dr. Webb had practiced in Lexington since 1946. He was a diplomate of the American Board of Surgeons, Kentucky Surgical Society and the American College of Surgeons.

COUNTY SOCIETY REPORTS

Scott

The Scott County Medical Society held their regular monthly meeting on October 4 at the John Graves Ford Memorial Hospital in Georgetown.

The following members attended: J. C. Cantrill, M.D., W. S. Allphin, M.D., F. W. Wilt, M.D., H. G. Wells, M.D., A. F. Smith, M.D, C. R. Lewis, M.D., and H. V. Johnson, M.D.

The Society discussed the question of having the Scott County Medical Society placed in some other councilor district. It was suggested that an inquiry be sent to the Judiciary Council to determine procedure in moving to another district.

Dr. Wells reported on activity of the House of Delegates during the KSMA annual meeting in September.

The secretary made a report on the number of polio shots given since April 1, 1956, as follows:

By Private Physicians		By Health Department	
1st —	760	1st —	722
2nd —	535	2nd —	611
3rd —	42	3rd —	123
Total	1337		1456

A motion was made and seconded that charges on calls after midnight be reduced to a minimum of five dollars. The motion carried.

H. V. Johnson, M.D., Secretary

McCracken County Medical Society

Harold Priddle, M.D., presided at the September 26 meeting of the McCracken County Medical Society.

A paper was presented by Neil Ward, M.D., on "Some Aspects of Industrial Medicine."

Following the reading of a letter regarding the coming Diabetes Detection Drive, Eugene Blake moved the Diabetic Committee be empowered to obtain necessary testing material. The motion passed.

The name of Theodore Koss, M.D., was brought before the Society for admission. In the absence of the Credentials Committee chairman, Dr. Blake

(Continued on Page 996)

NEW

For Pain-Free

of everyday

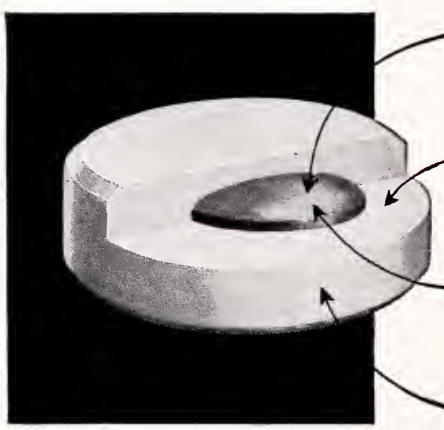
In "Rheumatism"*

M *ultiple*

TEMP

combine:

THE PROPER FORMULA
PROPERLY FORMULATED



Physical separation of the steroid component from the aluminum hydroxide as provided by the Multiple Compressed Tablet construction assures full potency and stability of prednisolone.

PREDNISOLONE (*1 mg.*).

+

ASPIRIN (*0.3 Gm.*).....

+

ASCORBIC ACID (*50 mg.*)

+

ANTACID (*0.2 Gm.*).....

*Early rheumatoid arthritis
Rheumatoid spondylitis
Osteoarthritis
Still's disease
Psoriatic arthritis
Bursitis
Synovitis
Tenosynovitis
Myositis
Fibrositis
Neuritis

Performance

activities

Patients



Compressed Tablets

OGEN®

..... for anti-inflammatory, anti-rheumatic benefits *at effective low dosage.*

..... for analgesia plus additional anti-rheumatic activity.

..... for anti-stress support that guards against adrenal ascorbic acid depletion.
(Ascorbic Acid present as 60 mg. Sodium Ascorbate.)

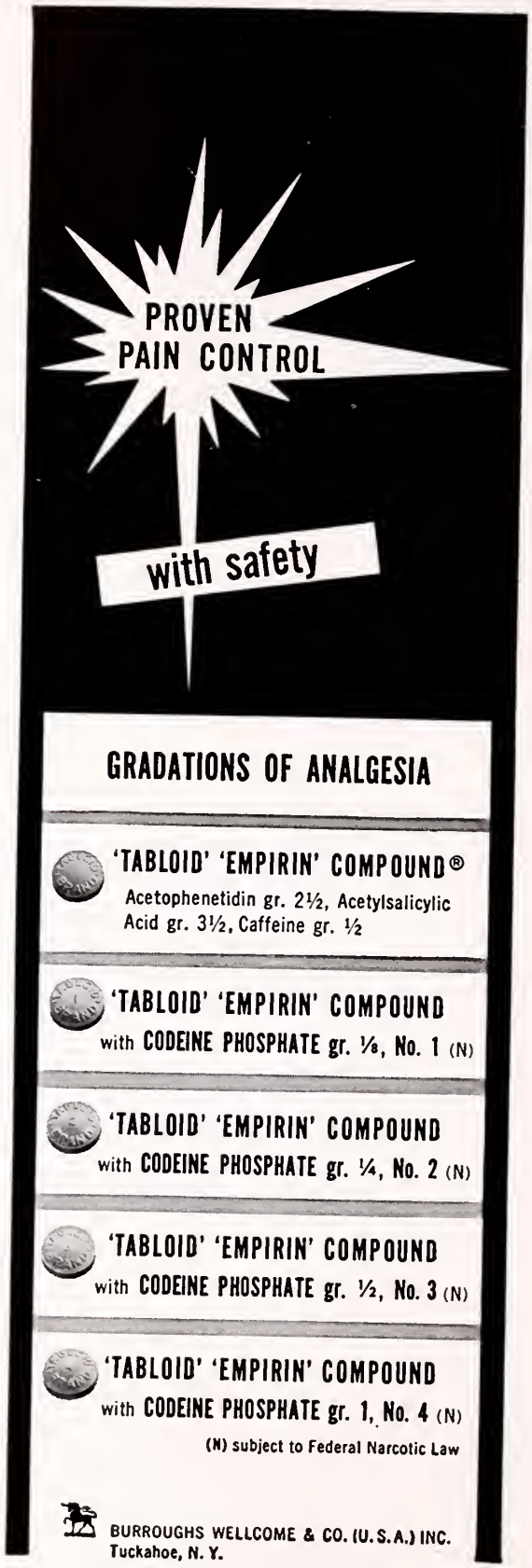
..... dried aluminum hydroxide gel minimizes the possibility of gastric distress.

DOSAGE: *1-4 TEMPOGEN Tablets t.i.d. or q.i.d. (TEMPOGEN Forte, 1 or 2 tablets t.i.d. or q.i.d.) for one or two weeks. Then lower by 1 tablet every four or five days to maintenance level.*

SUPPLIED: *TEMPOGEN and TEMPOGEN Forte —in bottles of 100 Multiple Compressed Tablets. (TEMPOGEN Forte provides 2 mg. of prednisolone.)*

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.



County Society Reports

(Continued from Page 993)

moved Dr. Koss be accepted contingent upon the report of the Censure Committee.

A letter from the Veterans Administration regarding available positions for physicians was read, following a letter from the Kentucky Heart Association regarding its newly instituted Newsletter was read.

General discussion followed Dr. Stryker's presentation of the problem of a proposed Mental Health Clinic for emotional health problems.

A motion, introduced by Dr. Billington, that the McCracken County Medical Society go on record as favoring the attaining of a grant through the State Health Department for a Mental Retardiation Clinic was passed.

Joe Mitchell, a member of the local Heart Committee, outlined his committee's work and plans, and called for the cooperation of the Society. A move that the final decision be referred to internists and pediatricians, who would be responsible for the work, was passed.

Frank Moore, M.D., chief of the Bowling Green Heart Clinic, outlined its operation for the past three years. Mr. Thornbury of the Kentucky Heart Association discussed the possibility of establishing a Heart Clinic in Paducah to study indigent heart patients.

C. P. Orr, M.D., Secretary
McCracken County Medical Society

Shelby-Oldham County

The September meeting of the Shelby-Oldham County Medical Society was held at the Stone Inn at Simpsonville.

Twenty-seven members and guests were present at the dinner meeting.

Scientific interest in the meeting was directed to "Cerebral Hemorrhage," the subject of a talk by Carl Turrell, M.D., Louisville. Dr. Turrell used slides effectively with the presentation.

During the business session, W. K. Skaggs, M.D., Taylorsville, was named as an associate member.

The next meeting will be held October 27 at Stone Inn, Simpsonville.

C. C. Risk, Secretary

Mission Medic is TV Subject

Missionary medicine will be the theme of a "March of Medicine" telecast over NBC-TV on Tuesday, Nov. 27, at 8:30 p.m., CST.

It will depict the daily activities of John E. Ross, M.D., who served eight years as a mission doctor in the Belgian Congo. Dr. Ross (a native Californian and graduate of the Indiana School of Medicine) established a leprosarium soon after arriving in Africa. The American Medical Association and the Smith, Kline and French Laboratories are sponsoring the program.

"The mercurial diuretics have the justified reputation of being the most powerful and consistently effective of all diuretic drugs."*

TABLET
NEOHYDRIN®

*Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 847.

07756

Malpractice Prophylaxis

With us
a doctor's involvement
in malpractice charges
are as confidential
as his own relations with his
patient

Specialized Service makes our doctor safer

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively
since 1899

LOUISVILLE Office
Calvin Bimer, Representative
3119 Hewitt Ave.
Tel. Glendale 8-3060
If no answer, call Clay 3636

PROVEN
PAIN CONTROL
with sedation

GRADATIONS OF ANALGESIA
with light sedation

'EMPIRAL'®

Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½

'CODEMPIRAL'® No. 2(N)

Codeine Phosphate	gr. ¼
Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½

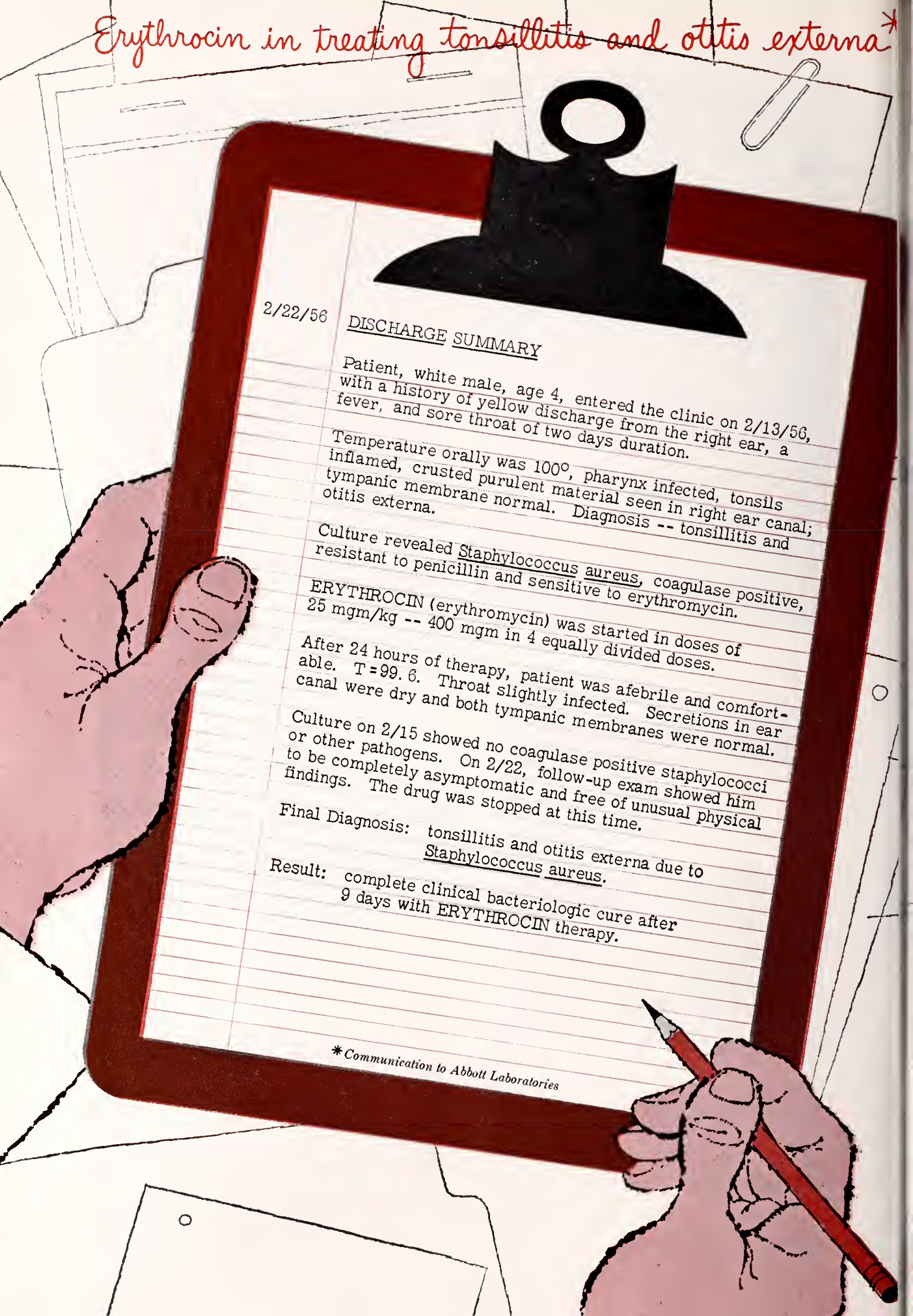
'CODEMPIRAL'® No. 3(N)

Codeine Phosphate	gr. ½
Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½

(N) subject to Federal Narcotic Law

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N. Y.

Erythrocin in treating tonsillitis and otitis externa*



2/22/56 DISCHARGE SUMMARY

Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.

Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.

Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.

ERYTHROCIN (erythromycin) was started in doses of 25 mgm/kg -- 400 mgm in 4 equally divided doses.

After 24 hours of therapy, patient was afebrile and comfortable. T = 99.6. Throat slightly infected. Secretions in ear canal were dry and both tympanic membranes were normal.

Culture on 2/15 showed no coagulase positive staphylococci or other pathogens. On 2/22, follow-up exam showed him to be completely asymptomatic and free of unusual physical findings. The drug was stopped at this time.

Final Diagnosis: tonsillitis and otitis externa due to Staphylococcus aureus.

Result: complete clinical bacteriologic cure after 9 days with ERYTHROCIN therapy.

*Communication to Abbott Laboratories

"clinical response good or excellent"

In one recent study, 18 patients with acute follicular tonsillitis and septic sore throat, were given erythromycin. Infecting organism was *Str. pyogenes*. The investigator stated, "*In all 18, the clinical response could be regarded as either good or excellent.*"[1]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when your prescription reads *Filmtab* ERYTHROCIN Stearate.

"toxicity lower in erythromycin-treated patients"

After a study of 208 patients treated with erythromycin (78), procaine penicillin (78) and a placebo (52), the investigator stated: "*. . . the incidence of toxicity* (compared to procaine penicillin) *was significantly lower in the erythromycin-treated patients.*"[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. Also, allergic reactions rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), is available in bottles of 25 and 100, at all pharmacies.

Abbott

® Filmtab—Film sealed tablets, Abbott; pat. applied for.

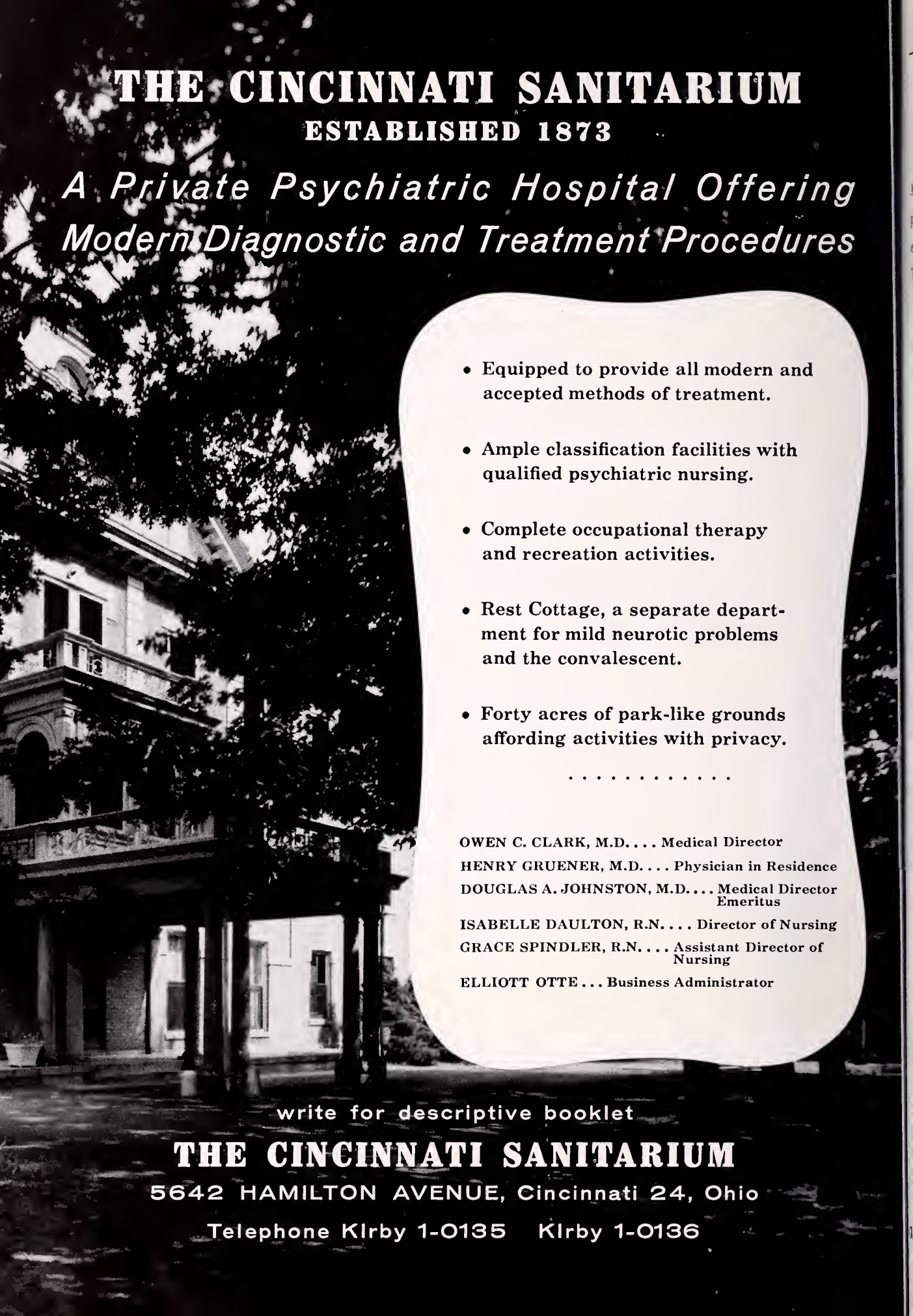
1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 29, New York, Medical Encyclopedia, Inc., 1955.
Idem p. 30.

filmtab®

Erythrocin® STEARATE

(Erythromycin Stearate, Abbott)

611243



THE CINCINNATI SANITARIUM

ESTABLISHED 1873

A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
- Ample classification facilities with qualified psychiatric nursing.
- Complete occupational therapy and recreation activities.
- Rest Cottage, a separate department for mild neurotic problems and the convalescent.
- Forty acres of park-like grounds affording activities with privacy.

. . . . . .

OWEN C. CLARK, M.D. . . . Medical Director
HENRY GRUENER, M.D. . . . Physician in Residence
DOUGLAS A. JOHNSTON, M.D. . . . Medical Director Emeritus
ISABELLE DAULTON, R.N. . . . Director of Nursing
GRACE SPINDLER, R.N. . . . Assistant Director of Nursing
ELLIOTT OTTE . . . Business Administrator

write for descriptive booklet

THE CINCINNATI SANITARIUM

5642 HAMILTON AVENUE, Cincinnati 24, Ohio

Telephone Kirby 1-0135 Kirby 1-0136

Doctor Disabled

OFFICE EXPENSE CONTINUES

At last, here is the practical solution to this problem - - - an insurance policy to pay your expenses, with the premium eligible as a Tax Deduction.

Latest Tax ruling provides that premiums on Health and Accident insurance are not deductible unless the policy states that it is for the express purpose of meeting business overhead expenses.

Ask your Accountant or Lawyer about this question and then ask us to explain this coverage.

W. R. LONG & ASSOCIATES
1534 Bardstown Road—Louisville, Ky.

Without obligation to me I would like to have more information on your office expense policy. I am in good health and was

born .....
Month Day Year

Name .....

Address .....

OCULISTS' PRESCRIPTIONS EXCLUSIVELY

MUTH OPTICAL COMPANY

Prescription Opticians

665 S. 4th Brown Hotel Building Louisville 2

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction

REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Clearview

On The Kratzville Road

EVANSVILLE, IND.

TELEPHONE 5-6181

A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.

SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery

ELECTROENCEPHALOGRAPH — CLINICAL LABORATORY—EKG AND BMR EQUIPMENT—STEREOSCOPIC X-RAY — HYDROTHERAPY.

ALBERT J. CREVELLO, M.D.
Diplomate, American Board of Psychiatry & Neurology, Inc.
MEDICAL DIRECTOR

little

How to win friends ...



The Best Tasting
Aspirin you can prescribe.

The Flavor Remains Stable
down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION
of Sterling Drug Inc.
1450 Broadway, New York 18, N. Y.



For preventing
and treating
upper respiratory
infections

Achrocidin*

Tetracycline-Antihistamine-Analgesic Compound

Available on prescription only

ACHROMYCIN® Tetracycline . . 125 mg.
Phenacetin . . . . . 120 mg.
Caffeine . . . . . 30 mg.
Salicylamide . . . . . 150 mg.
Chlorothen Citrate . . . . . 25 mg.
Bottle of 24 tablets.

ACHROCIDIN is a well-balanced, comprehensive formula directly modifying the complications of the common cold or upper respiratory infections.

In addition to the direct benefit of rapid symptomatic improvement, ACHROCIDIN promptly controls the bacterial component frequently responsible for the development in susceptible individuals of sequelae such as otitis media, sinusitis, adenitis, and bronchitis.

ACHROCIDIN is convenient for you to prescribe—easy for the patient to take. Average adult dose: two tablets three or four times daily.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Lederle

*TRADEMARK

CROCKER-FELS COMPANY
SERVING PHYSICIANS AND HOSPITALS SINCE 1882



If you're looking for an unusually attractive examining room suite, unusually serviceable equipment, and special features to make your work easier—you'll find them in Hamilton's Steeltone, shown above. And it's available in an array of decorators' colors: white deluxe, cream white, jade green, washington blue, coral, and silver metallic.

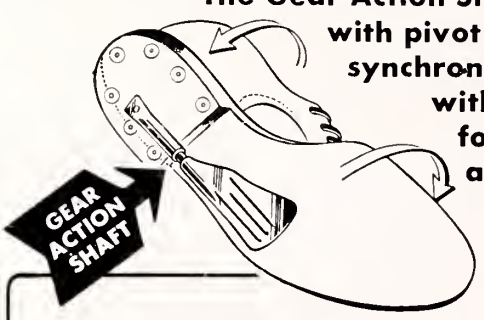
The name Hamilton is synonymous with quality.

The Crocker-Fels Company

624 S. THIRD ST. CLay 8855 LOUISVILLE, KY.

Ask about our liberal financing plan

The Gear Action Shoe★ with pivot arch synchronizing with the foot in action



- Insole extension and wedge at inner corner of heel where support is most needed.
- The patented arch support construction is guoranteed not to break down.
- Innersoles guoranteed not to crack or collopse.
- Foot-so-Port losts designed ond the shoe construction engineered with orthopedic odvice.
- Conductive Shoes for surgicol ond operoting room personnel. N.B.F.U. specificotions.
- ★ We are olso the manufacturer of the Geor-Action Shoe designed by noted orthopedic surgeon.
- We make more shoes for polio, club feet ond disobled feet than ony other shoe manufocturer.

Send for free booklet, "The Preservotion of the Function of the Foot Boloncing ond Synchronizing the Shoe with the Foot."

Write for detoils or contoct your locol **FOOT-SO-PORT** *Shoe Agency. Refer to your Clossified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.
A Division of Musebeck Shoe Company

NEW CASTLE SANITARIUM

Telephone 3621
NEW CASTLE, KY.

For the care of
CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the American Hospital Association
Member of the American Assn. of Nursing Homes
Licensed and Approved by the State of Kentucky

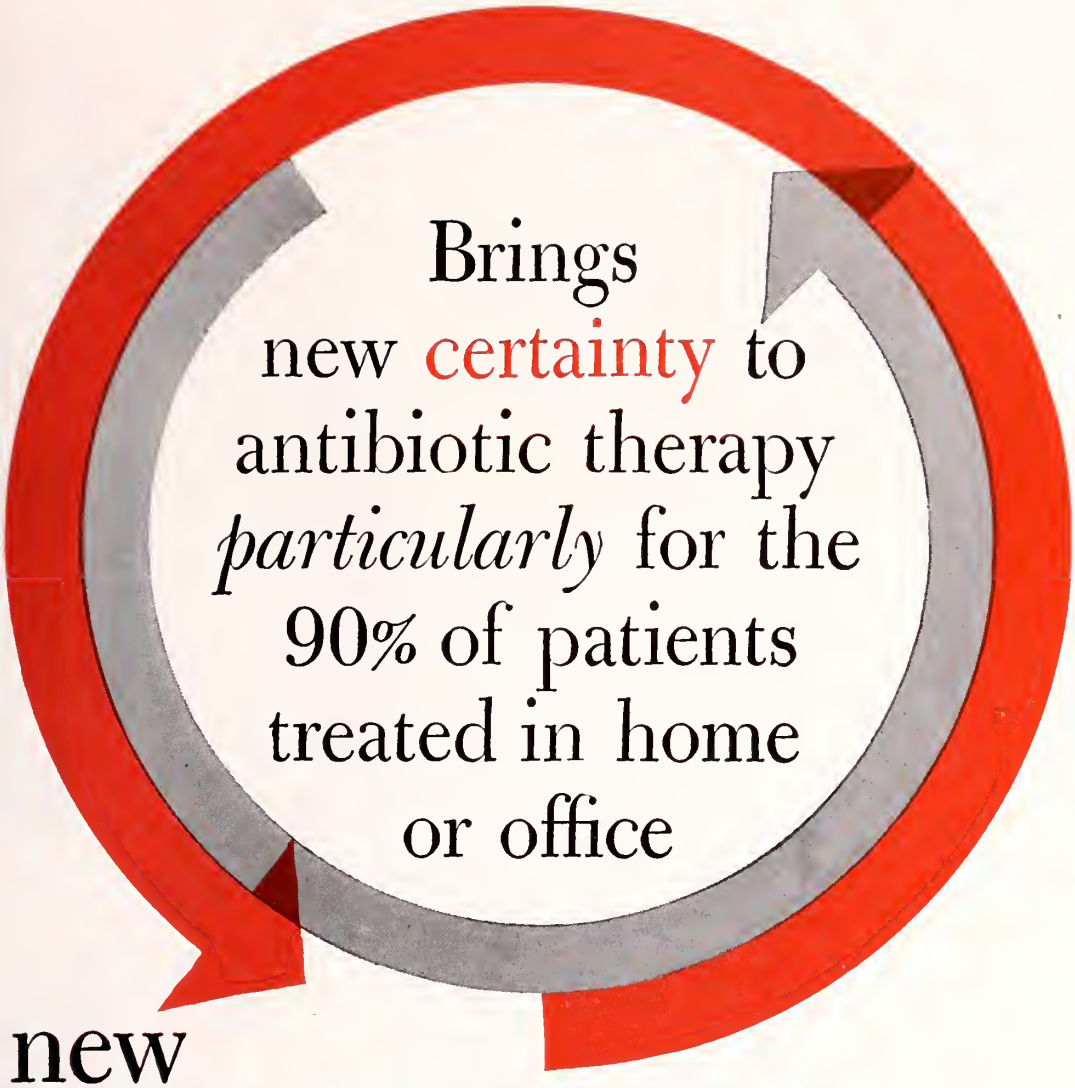
SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE

PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS

24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES
New Selectemp Modulated Steam Heat With Filtered Air For Maximum Comfort and Safety
Protected Throughout With Automatic Fire Detection and Alarm System

IRA O. WALLACE, Administrator



new

Sigmamycin*

OLEANDOMYCIN TETRACYCLINE

*TRADEMARK

a new maximum
in therapeutic
effectiveness

a new maximum
in protection
against
resistance

a new maximum
in safety and
toleration

multi-spectrum
synergistically
strengthened...



Sigma

OLEANDOMYCIN TETRACYCLINE

tient
pulation



nycin*

a new certainty

in antibiotic therapy, particularly for the 90% of patients treated at home and in the office

Superior control of infectious diseases through superior control of the changing microbial population is now available in a new formulation of tetracycline, outstanding broad-spectrum antibiotic, with oleandomycin, Pfizer-discovered new antimicrobial agent which controls resistant strains. The synergistic combination now brings to antibiotic therapy: (1) a new fuller antimicrobial spectrum which includes even "resistant" staphylococci; (2) new superior protection against emergence of *new* resistant strains; (3) new superior safety and toleration. *TRADEMARK

Pfizer

superior control of infectious disease through superior control of the changing microbial population

new

Sigmamycin*

OLEANDOMYCIN TETRACYCLINE

A synergistically strengthened multi-spectrum antibiotic

Sigmamycin is a new antibiotic formulation providing: (1) the unsurpassed broad-spectrum activity of tetracycline, the outstanding broad-spectrum antibiotic discovered and identified by Pfizer; (2) the action of oleandomycin, the new antimicrobial agent which combats those strains, particularly among staphylococci, now resistant to tetracycline and other antibiotics.

Sigmamycin embodies a new concept in the use of antibiotics, for with this new synergistically active preparation, the development of refractory pathogens and their emergence as important sources of superinfection are more fully controlled.

New superior safety and toleration— Sigmamycin brings to antibiotic therapy new superior safety, new unexcelled toleration because: (1) tetracycline, an outstandingly well-tolerated antibiotic, is formulated with oleandomycin, also known to be remarkably free of adverse reactions; (2) the synergism between oleandomycin and tetracycline enhances antimicrobial potency.

Dosage: 1 to 2 capsules q.i.d.

Supplied: Capsules, 250 mg. (oleandomycin 83 mg., tetracycline 167 mg.) Bottles of 16 and 100.

*TRADEMARK

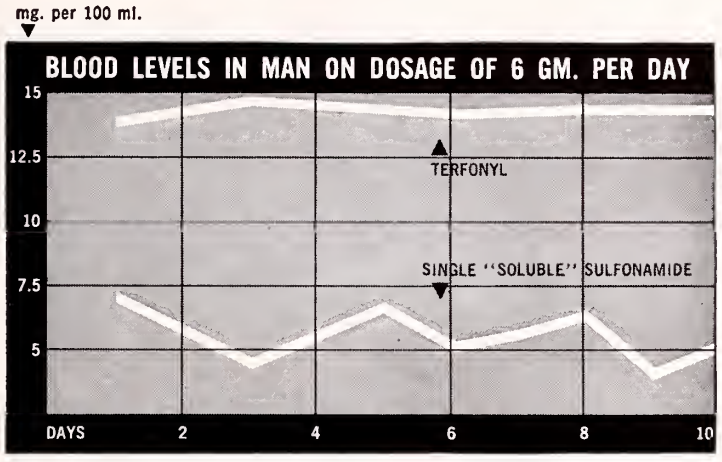
Pfizer

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.

maximum efficacy with minimum risk

Terfonyl

SQUIBB METH-DIA-MER SULFONAMIDES



– After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

Terfonyl is absorbed as well as single "soluble" sulfonamides, but is eliminated at a slower rate. For this reason, Terfonyl blood levels are much higher.

In experimental infections (Klebsiella, Pneumococcus, Streptococcus), Meth-Dia-Mer sulfonamides have been shown to be from three to four times more effective on a weight basis than single "soluble" sulfonamides.

Toxicity is minimal because normal dosage provides only one-third the normal amount of each sulfonamide. The body handles each component as though it were present alone, although therapeutic effects are additive.

Terfonyl Tablets, 0.5 Gm., bottles of 100 and 1000.
Terfonyl Suspension, 0.5 Gm. per 5 ml., pint bottles.

0.167 Gm. each of sulfamethazine, sulfadiazine and sulfamerazine per tablet or per 5 ml. teaspoonful of suspension.

SQUIBB

'TERFONYL'® IS A SQUIBB TRADEMARK

ANNOUNCING

'CATHO



more effective
in clinically
important infections
than any other
antibiotic

FOR MOST INFECTIONS

CILLIN

NEW

(NOVOBIOCIN-PENICILLIN G. MERCK)

THE ANTIBIOTIC PRODUCT MOST LIKELY TO BE EFFECTIVE

COMPARE THESE ADVANTAGES:

1. Proved effectiveness in the largest number of clinically important infections including those caused by antibiotic-resistant *staphylococci* and proteus.
2. Therapeutic, *bactericidal* blood levels are promptly achieved.
3. Exceptionally well tolerated; patient sensitivity reactions are rare at recommended dosage.
4. No yeast or fungal super-infections nor any antibiotic-induced enteritis, vaginitis or proctitis have been reported following CATHOCILLIN.
5. No problems of cross-resistance have been encountered with CATHOCILLIN.
6. The normal intestinal flora is not disturbed by CATHOCILLIN.

DOSAGE: *for adults—two capsules q.i.d.; for children under 100 lbs.—dosage in proportion to weight (e.g. one capsule q.i.d. for a child weighing 50 lbs.).*

CONSIDER CATHOCILLIN FIRST

—for these clinically important infections: tonsillitis; pharyngitis; pneumonia; otitis media; cervical lymphadenitis; streptococcal sore throat; infected tooth sockets; Vincent's infection; acne and superficial skin infections; impetigo; boils, furuncles and carbuncles; lung abscess; bronchitis; mastitis; osteomyelitis; wound infections; postoperative wound infections and infected lacerations; staphylococcal enteritis, staphylococcal diarrhea of the newborn; peritonitis (caused by susceptible organisms); pelvic inflammatory disease; gonorrhea; gonococcal arthritis; urethritis; scarlet fever; erysipelas.

SUPPLIED: *Blue and white capsules of* 'CATHOCILLIN' *—each containing 125 mg. of* 'CATHOMYCIN' *(as Sodium Novobiocin, Merck) and 75 mg. (125,000 units) Potassium Penicillin G; bottles of 16.*

In one prescription the one antibiotic product most likely to be effective

MSD

MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

"Patients without primary renal disease, but with albuminuria and high nonprotein nitrogen due to congestive circulatory changes, can be adequately and safely treated with Neohydrin for long periods of time."*

*Griffith, G. C.; Dimitroff, S. P., and Thorner, M. C.: Ann. Int. Med. 45:7, 1956.

07656

SECLUSION MATERNITY



FAIRMOUNT HOSPITAL

FOR UNMARRIED GIRLS

Est. 1909

Private sanitarium with certified obstetrician in charge. Folder fully describing services FREE on request. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

Write for Information

HELEN AMOS

4911 East 27th St.

Kansas City, Mo.

Phone: WA. 3-3577

WANT AD

Opening for a general practitioner in a section of Kentucky. J. E. Edwards, M.D., who has practiced in Lancaster since 1916 is retiring. He will vacate his office which he owns. Lancaster has a new 30-bed hospital and is surrounded by a very fertile farming region.

"the most critical inspection yet devised for an eye-glass lens"--

Your prescription filled by us will be processed to the prescription with first quality materials; the glass and surfaces will be tested for precision of workmanship—and your lenses checked for accuracy of power —only a perfect lens passes the Southern Optical test.



Southern Optical COMPANY

CONTACT LENSES
(Fluidless Lacrilens—Microlens)

ARTIFICIAL EYES
(Custom Plastic—Glass)

HOME OWNED SINCE 1897

4th and Chestnut
334 W. Broadway
LOUISVILLE



the Emblems of RELIABLE PROTECTION

We cordially invite your inquiry
for application for membership
which affords protection against
loss of income from accident and
sickness as well as benefits for
hospital expenses for you and
all your dependents

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL BENEFITS GO TO

$4,500,000 ASSETS
$23,800,000 PAID FOR BENEFITS SINCE ORGANIZATION

Since 1902

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

EVERY WOMAN WHO SUFFERS IN THE MENOPAUSE DESERVES "PREMARIN"®

widely used natural, oral estrogen

AYERST LABORATORIES
New York, N.Y. • Montreal, Canada
5645

CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of
mental and nervous disorders, and
addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465
334 W. BROADWAY
LOUISVILLE, KENTUCKY

WAbash 6725

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**

( ) **Centralized Bookkeeping**
(Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**

Choice location for general practice. A recent death makes office with adjacent home in separate building available. Small town atmosphere. The one other physician in town welcomes help. Practice should be assured immediately. Nine miles from county hospital and about 35 from the Jeffersonville bridge. Ideal for individual who needs immediate practice and yet desires to retain Louisville connections.

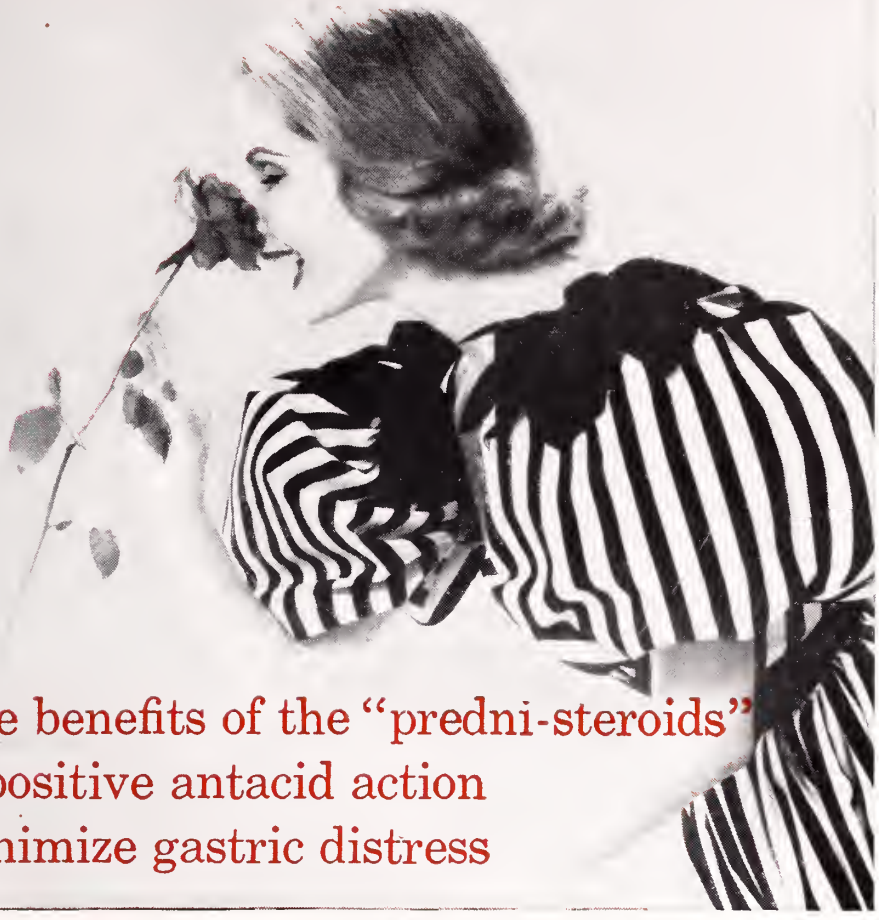
Contact:

MRS. FRANK GREEN, Rushville, Indiana

PLEASE NOTICE

Advertising space in The Journal of the Kentucky State Medical Association is worth just what you make it. All advertisements appearing in The Journal have been carefully screened in order that our readers may depend on them. When you buy from firms advertising in The Journal you protect yourself against questionable products and you increase the value of this, your own Journal, to its advertisers. Remember this, and use these pages as your buying guide.

in respiratory allergies



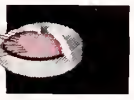
all the benefits of the "predni-steroids"
plus positive antacid action
to minimize gastric distress

ROUTINELY ACHIEVED WITH

'Co-Deltra'
(Prednisone Buffered)



Multiple
Compressed
Tablets



'Co-Hydeltra'
(Prednisolone Buffered)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al., J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al., J.A.M.A.* 158:459 (June 11) 1955.

MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are trademarks of* MERCK & CO., INC.

NEW

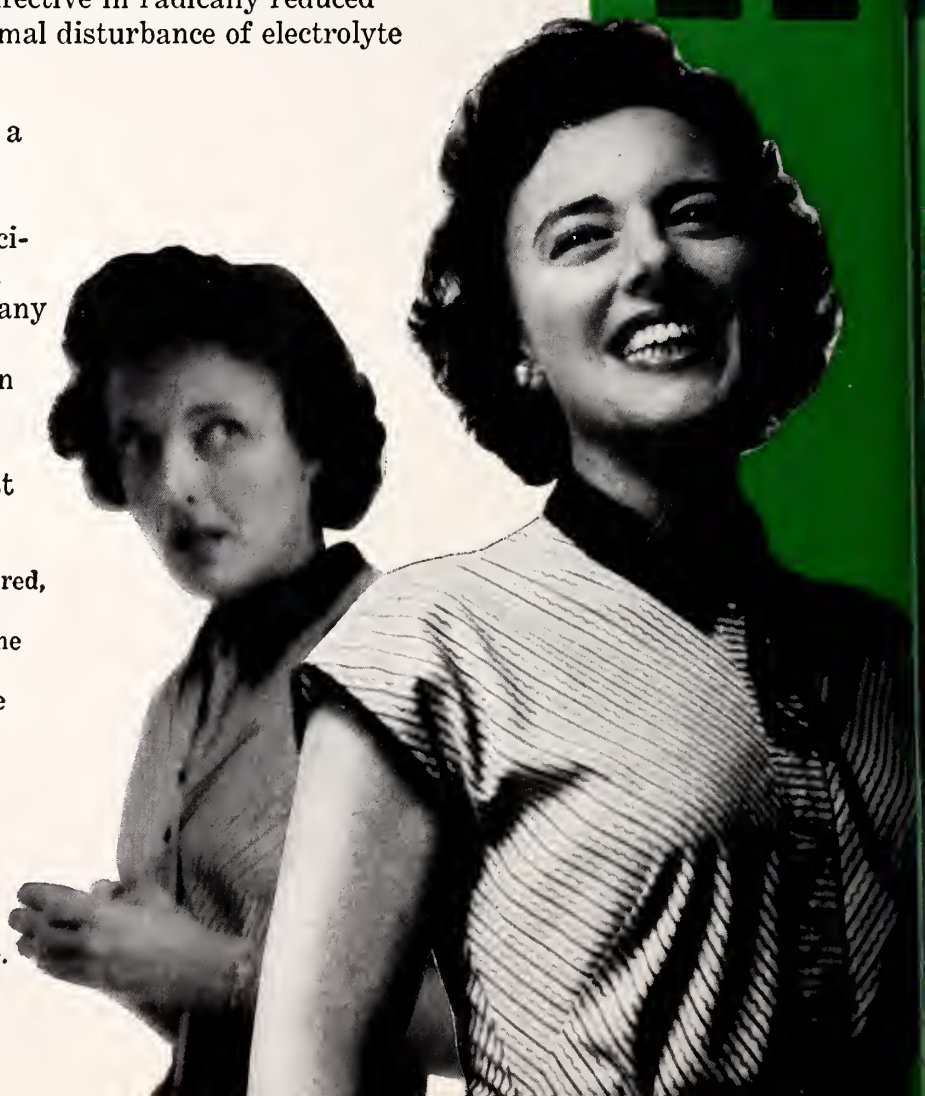
ATARAXOID is a unique, new combination of STERANE and ATARAX, which now permits simultaneous symptomatic control and reduction of attendant anxiety and apprehension in rheumatoid arthritis and other indications.

The added tranquilizer control, desirably easing mental stress, also directly assists clinical progress. It minimizes the chance of exacerbation related to emotional strain and facilitates patient confidence and cooperation in the therapeutic program toward maximum rehabilitation.

ATARAXOID exerts the anti-rheumatic, anti-inflammatory activity of STERANE distinctly superior to previous steroids, effective in radically reduced dosage, and with minimal disturbance of electrolyte and fluid metabolism.

The ataractic effect is a central neuro-relaxing action – the result of a marked cerebral specificity – free of mental fogging and devoid of any major complications: no liver, blood or brain damage. This peace-of-mind component is also used in the lowest dosage range.

Supplied: Each green, scored, ATARAXOID oral tablet contains 5 mg. prednisolone (STERANE) and 10 mg. hydroxyzine hydrochloride (ATARAX). Bottles of 30 and 100.



PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

the first and only ataraxic-corticoid

araxoid*

prednisolone and hydroxyzine

Pfizer

combining the newest, safest tranquilizer, ATARAX® + the newest, most effective steroid, STERANE® (prednisolone)

simultaneously controls the symptoms and the apprehension

In Rheumatoid Arthritis, other collagen diseases, bronchial asthma and inflammatory dermatoses

*Trademark

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS—1956-57

Richard R. Slucher, 2202 Seiger Villa, Louisville ..... President
Edward B. Mersch, 92 Arcadia, Covington ..... President-elect
Gant Gaither, 109½ East 7th Street, Hopkinsville ..... Immediate Past President
Karl D. Winter, 908 Heyburn Building, Louisville ..... Vice-President (Central)
Carl Norfleet, Somerset ..... Vice-President (Eastern)
Charles R. Yancey, 1110 South Main St., Hopkinsville ..... Vice-President (Western)
Woodford B. Troutman, 1616 Heyburn Building, Louisville ..... Secretary
Woodford B. Troutman, 1616 Heyburn Building, Louisville ..... Treasurer
Clyde C. Sparks, Mayo Arcade Building, Ashland ..... Speaker—House of Delegates
George W. Pedigo, Jr., 810 Heyburn Bldg., Louisville ..... Vice-Speaker—House of Delegates
Hugh Mahaffey, Richmond ..... Chairman of the Council
L. O. Toomey, 544 East Main Street, Bowling Green ..... Vice-Chairman of the Council

DELEGATES TO THE A. M. A.

	Term Expires
W. Clark Bailey, Harlan	1958
Robert C. Long, 806 Heyburn Building, Louisville (Alternate)	1958
W. Vinson Pierce, 33 East Seventh St., Covington	1957
Leon Higdon, 333 Broadway, Paducah (Alternate)	1957

COUNCILORS

		Term Expires
First District	J. Vernon Pace, 709-10 Citizens Bank Bldg., Paducah	1959
Second District	Walter L. O'Nan, 700 N. Elm St., Henderson	1958
Third District	Ralph D. Lynn, Elkton	1959
Fourth District	W. Keith Crume, Bardstown	1959
Fifth District	Carlisle Morse, 3612 Lexington Rd., Louisville	1957
Sixth District	L. O. Toomey, 544 E. Main St., Bowling Green	1957
Seventh District	Branham B. Baughman, 401 W. Main St., Frankfort	1958
Eighth District	Norman Adair, 630 Scott Street, Covington	1957
Ninth District	J. M. Stevenson, Brooksville	1958
Tenth District	J. Farra Van Meter, 183 N. Upper St., Lexington	1958
Eleventh District	Hugh Mahaffey, Richmond	1957
Twelfth District	Garnett J. Sweeney, Liberty	1959
Thirteenth District	Charles B. Johnson, Russell	1958
Fourteenth District	Charles C. Rutledge, Hazard	1959
Fifteenth District	Charles B. Stacy, Pineville	1957

BUYERS GUIDE

JOURNAL OF THE KENTUCKY STATE MEDICAL ASSOCIATION, NOVEMBER, 1956

Abbott Laboratories 998-99
American Meat Institute 937
Ames Co. Inc., ... 1019
Ayerst Laboratories 1013
Baker Laboratories 935
Bayer Aspirin 1002
Brayton Pharmaceutical Co. 991
Brown & Williamson Tob. Co. 921
Burroughs-Welcome Co. 925-996-997
Chicago Medical Society 989
Ciba Pharmaceutical Co., ... 988
Cincinnati Sanitarium 1000
City View Sanitarium 1014
Clearview Sanitarium 1001
Coca-Cola Co., ... 992
Corn Products Ref. Co., ... 923
Crocker-Fels Co., ... 1004
Fairmont Hosp., ... 1012
Foot-So-Port Shoe Co., ... 1004
Geigy Pharmaceutical Co., ... 941
The Keeley Institute 1001
Knox Gelatine Co., ... 984
Lakeside Labs. 932-997-1012
Lederle Laboratories 934-68-69-1003
Eli Lilly & Co., ... 946
W. R. Long Ins. Co., ... 1001
Louisville Med. Dental Business Bureau 1014
Medical Protective Co., ... 997
Merck, Sharp & Dohme 929-38-39-94-95-1010-11-15
Muth Optical Co., ... 1001
New Castle Sanitarium 1004
New York Polyclinic Med. Sch. & Hosp. 993
Parke, Davis & Co., ... 918-19
Chas. Pfizer & Co., ... 1005-6-7-8-16-17
Physicians Casualty Ins. Co., ... 1013
Pleasant Grove Hosp., ... 986
A. H. Robins Co., ... Insert
Schering Corporation 926-27-42-43
Scroggins Associates 985
G. D. Searle & Co., ... 975
Smith, Kline & French 945-1020
Southern Optical Co., ... 1012
E. R. Squibb & Sons 1009
Upjohn & Co., ... 930
Wallace Laboratories 980
Want Ad (Edwards) 1012
Want Ad (Green) 1010
Wayside Laboratories 993
Winthrop Laboratories 936-83
Wyeth, Inc., ... 922-31-90

new!
calmative



nostyn®
2-ethylcrotonylurea, AMES

the power of gentleness
for relief of daily tensions

• moderates anxiety and tension
• avoids depression, drowsiness, motor incoordination

different!

·NOSTYN is a new drug, a *calmative*
—not a hypnotic-sedative
—unrelated to any available chemopsychotherapeutic agent
·no evidence of cumulation or habituation
·does not cause diarrhea or gastric hyperacidity
·unusually wide margin of safety—no significant side effects

dosage: 150-300 mg. three or four times daily.

supplied: 300 mg. scored tablets, bottles of 48.

AMES COMPANY, INC • ELKHART, INDIANA

17656



'Thorazine' relieved this patient's anxiety, tension and fear and made it possible for him to return to work.

'THORAZINE' CASE REPORT

patient: Anxiety, tension, and a fear of going out alone made it impossible for this 36-year-old man to work. After other treatments had failed he was given 'Thorazine'.

response: "On 'Thorazine' medication, 100 mg. orally, daily, his anxiety and apprehension disappeared rapidly. The patient was able to go out alone and to work once again. His mood was actually gay and his co-workers were surprised at this change. He was now free from care whereas before he had been distressed by the slightest difficulty."

This case report is from the files of a general practitioner.

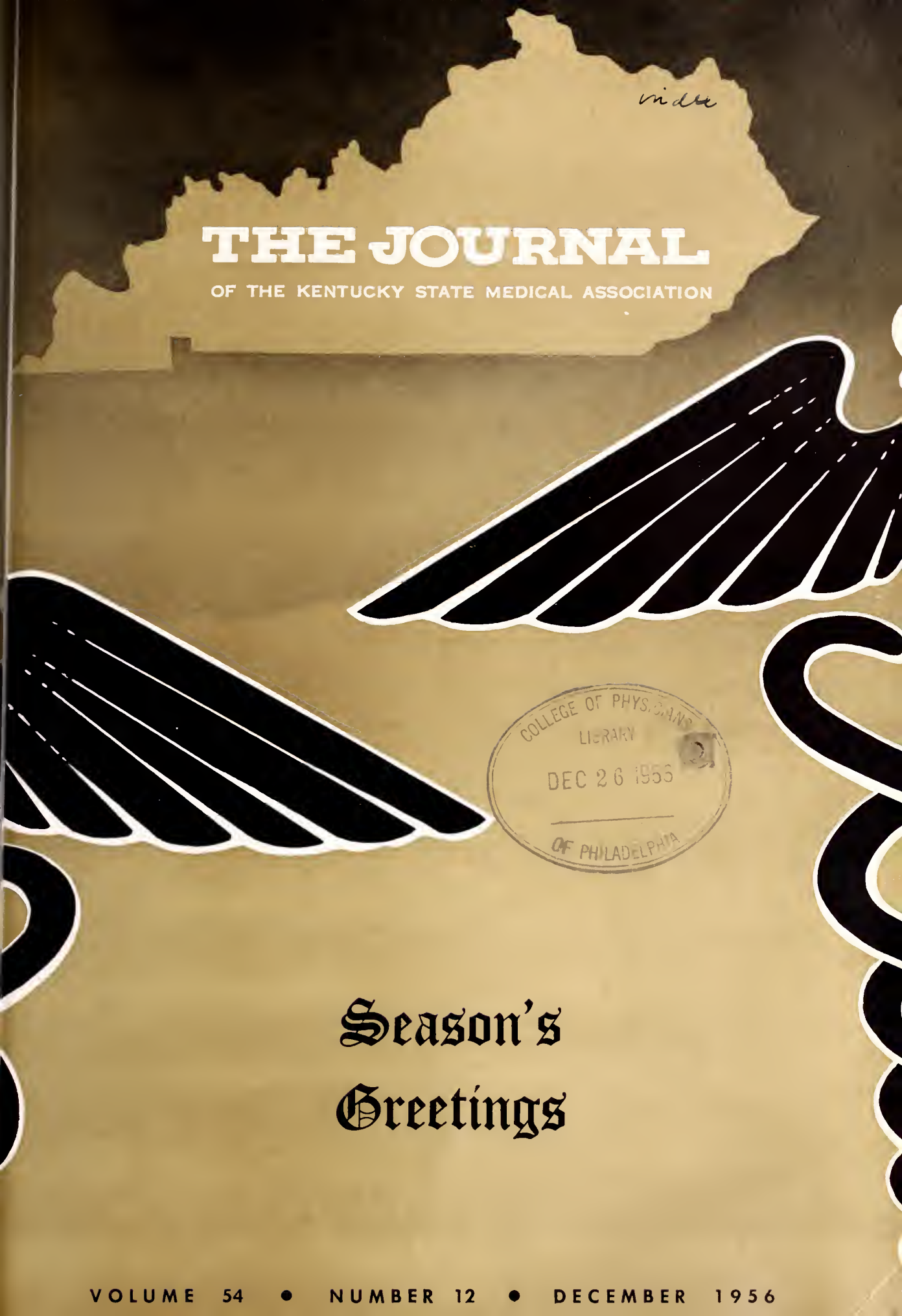
THORAZINE*

Available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

Smith, Kline & French Laboratories, Philadelphia

'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.



THE JOURNAL

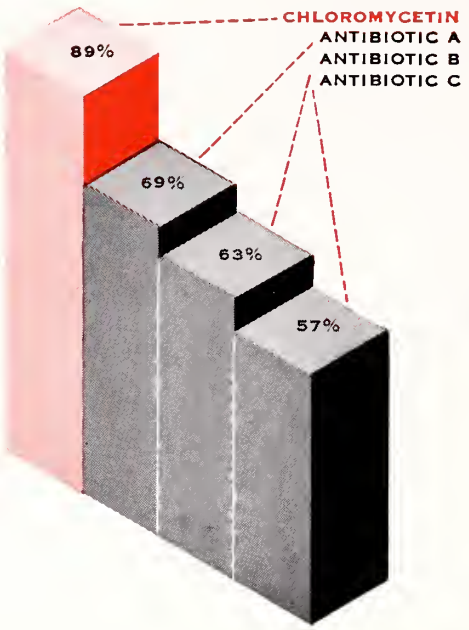
OF THE KENTUCKY STATE MEDICAL ASSOCIATION

COLLEGE OF PHYSICIANS
LIBRARY
DEC 26 1956
OF PHILADELPHIA

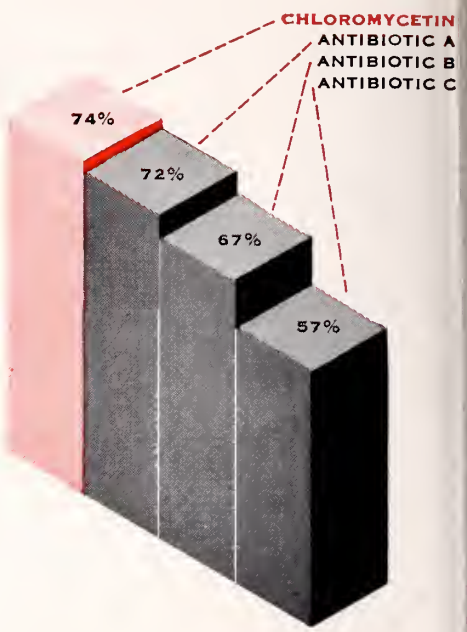
Season's Greetings

VOLUME 54 • NUMBER 12 • DECEMBER 1956

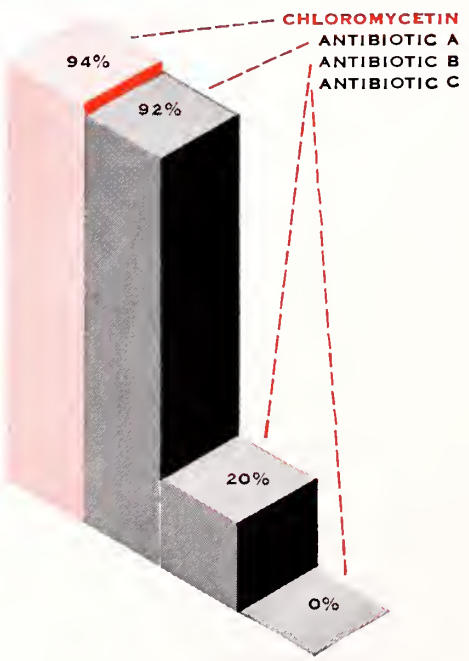
SENSITIVITY OF COMMON PATHOGENS TO **CHLOROMYCETIN** AND THREE OTHER MAJOR ANTIBIOTIC AGE



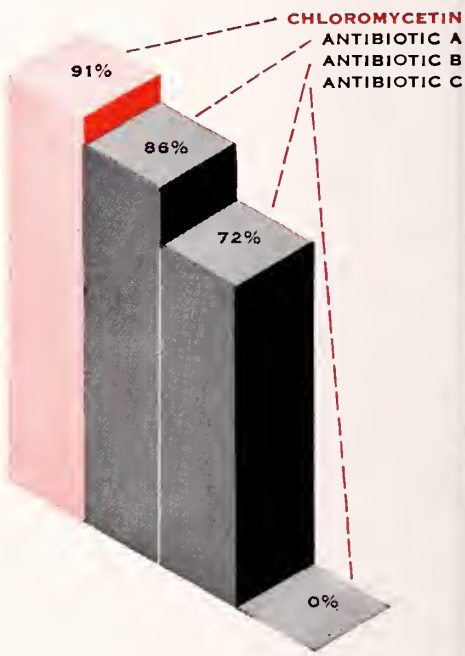
NONHEMOLYTIC MICROCOCCUS AUREUS
(363-418 STRAINS)



HEMOLYTIC MICROCOCCUS AUREUS
(729-776 STRAINS)



ESCHERICHIA COLI
(478-586 STRAINS)



AEROBACTER AEROGENES
(153-193 STRAINS)

greater antibacterial efficacy...

Chloromycetin®

for today's problem pathogens

Because of the increasing emergence of pathogenic strains resistant to commonly used antibiotics, judicious selection of the most effective agent is essential to successful therapy. *In vitro* sensitivity studies serve as a valuable guide to the antibiotic most likely to be most effective. Both clinical experience and sensitivity studies indicate the greater antibacterial efficacy of CHLOROMYCETIN (chloramphenicol, Parke-Davis) treatment for many resistant infections.[1-7]

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References (1) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305 (Jan. 22) 1955. (2) Austrian, R.: *New York J. Med.* 55:2475 (Sept. 1) 1955. (3) Murphy, F. D., & Waisbren, B. A., *in* Murphy, F. D.: Medical Emergencies: Diagnosis and Treatment, ed. 5, Philadelphia, F. A. Davis Company, 1955, p. 557. (4) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (5) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (6) Kass, E. H.: *Am. J. Med.* 18:764, 1955. (7) Tebrock, H. E., & Young, W. N.: *New York J. Med.* 55:1159 (Apr. 15) 1955.

is graph is adapted
om Altemeier, Cul-
rtson, Sherman, Cole,
lstun, & Fultz.[1]

MEDICAMENTA VERA · P & CO.

PARKE, DAVIS & COMPANY

DETROIT, MICHIGAN

The JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

GUY AUD, M.D.: *Editor*
J. P. SANFORD: *Managing Editor*
J. L. CHUMLEY, M.D.: *Scientific Editor*
J. C. BELL, M.D.: *Case Discussions Editor*
S. A. OVERSTREET, M.D.: *Med. Editorial Editor*
WALTER S. COE, M.D.: *Book Review Editor*
GAIL M. RANSDELL: *Organization Editor*
GIBBS-INMAN, LOUISVILLE: *Printers*

ADVISORY COMMITTEE TO THE EDITOR

James E. Hix, M.D. — Richard J. Rust, M.D., Chairman — Francis Massie, M.D.

BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1959	Term Expires July 1, 1958	Term Expires July 1, 1957
Robert E. Buten, M.D.	Harry D. Abell, M.D.	Carey C. Barrett, M.D.
Thomas Crume, Jr., M.D.	Henry B. Asman, M.D.	Joe Bush, M.D.
German P. Dillon, Jr., M.D.	Marion F. Beard, M.D.	Allen E. Grimes, M.D.
Pat Imes, M.D.	Rankin Blount, M.D.	Richard F. Grise, M.D.
Stanley Parks, M.D.	Glenn Bryant, M.D.	Billy Keller, M.D.
William Roland, M.D.	William C. Buschemeyer, M.D.	A. J. Miller, M.D.
Maurice Walsh, M.D.	Richard Elliott, M.D.	Robert Reeves, M.D.
James Ward, M.D.	Douglas Scott, M.D.	Charles R. Yancey, M.D.

Published at 620 S. Third Street, Louisville 2, Kentucky

Subscription $8.00 per year — Single Copy .80

Contents

SCIENTIFIC ARTICLES

The Selection of Patients for Radical Mastectomy, *George B. Sanders, M.D., David W. Kinnaird, M. D.* 1047
Clinical Otosclerosis—Fenestration or Staples Mobilization, *Arthur L. Juers, M.D.* 1056

CASE DISCUSSION

A Case of Appendicular Cutaneous Fistula 1059

SPECIAL FEATURES

Digest of Proceedings of the 1956 House of Delegates 1061
1956 Constitution and Bylaws of the KSMA 1100
Index 1124

EDITORIALS

Why? 1090
How Deep Is Your Conviction? 1090

ORGANIZATION SECTION

RH Leaders Plan for National Meet 1092
AMA Clinical Session Held in November 1092
Cincinnati Med. Academy 100 Yrs. Old 1092
Dr. McCarty Named Head SMA Council 1092
Dr. Adams Goes to Civil Defense Meet 1092
Council Governs Med. School Alumni 1093
Dr. Hancock Heads Blue Shield 1093
Eleventh Councilor District Meets 1093
Doctors' Aides Organize at Milwaukee 1093
Sixth Councilor District Has TB Panel 1093
Doctor-Lawyer Relations Filmed 1093
Nurse Increase Does Not Suffice 1093

REGULAR DEPARTMENTS

President's Page 1028
News Items 1094
In the Books 1032
In Memoriam 1099
Washington News Digest 1036
Student AMA 1094

Second Class Mail privileges authorized at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.



'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

always carry 'Thorazine' Ampuls in your bag

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

Erythromycin in the treatment of osteomyelitis*

8/3/55

CASE SUMMARY

On 6/2/55, patient, male, age 28, fell on an old fracture and refractured the middle third of the right femur, superimposed on an old osteomyelitis.

On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

On 8/3, the cast was removed and leg recast. Wound was in good condition with minimal drainage.

Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

Result: erythromycin aided healing of the old osteomyelitis and kept the infection under control.

* *Communication to Abbott Laboratories*

pecific against

occic infections

Specific—because you can actually pinpoint the therapy for coccic infections. That's because most bacterial respiratory infections are caused by staph-, strep-and pneumococci. And these are the very organisms most sensitive to ERYTHROCIN—even when in many cases they resist other antibiotics.

filmtab®

Erythrocin®

(Erythromycin, Abbott)
STEARATE

ith little risk of

erious side effects

Low toxicity—because ERYTHROCIN rarely alters intestinal flora. Thus, your patients seldom get gastroenteral side effects. Or loss of vitamin synthesis in the intestine. Virtually, no allergic reactions, either. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), bottles of 25 and 100. Abbott

filmtab®

Erythrocin®

(Erythromycin, Abbott)
STEARATE

® Filmtab—film-sealed tablets; pat. applied for

609216



message from the President

"Almighty God, be with me I humbly beseech Thee in Thy attendance in this holy hour. Give me becoming awe of Thy presence and grant me Thy direction and aid.

"I beseech Thee, that in confessing I may be humble and truly penitent in prayer, serious and devout in praise, grateful and sincere, and in hearing Thy word attentive and willing and desirous to be instructed.

"Direct me, Oh God, in performing this operation, for I am but an instrument in Thy hands and am but Thy servant. If it is Thy will, spare this poor afflicted woman. Oh, give me true faith in the atonement of Thy Son, Jesus Christ, or a love sufficient to procure Thy favor and blessing, that worshiping Thee in spirit and in truth my services may be accepted through His all-sufficient merit. Amen"

* * * * * *

We believe the above prayer, offered by Ephraim McDowell, M.D., as he prepared to perform his epoch-making operation December 25, 1809, on Jane Todd Crawford, expresses our sentiments at this Season far more effectively and eloquently than any Christmas message we might aspire to write.

R. R. Slucher

Richard R. Slucher, M.D.



In Colds... *Anywhere... Any time...*

Neo-Synephrine®

hydrochloride

Prompt and Prolonged Decongestion
Sinus Drainage and Aeration

NO IRRITATION • NO SEDATION • NO EXCITATION

- ✻**Nasal Solutions** 0.25%, 0.5% and 1%
- ✻**Nasal Spray** 0.5%
- ✻**Pediatric Nasal Spray** 0.25%,

} *plastic, unbreakable squeeze bottle leakproof, delivers a fine mist*

with Zephiran® chloride 1:5000, antibacterial wetting agent and preservative for greater efficiency

Neo-Synephrine (brand of phenylephrine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U.S. Pat. Off.

Winthrop LABORATORIES
NEW YORK 18, N. Y. • WINDSOR, ONT.



1956 ADVERTISERS

Abbott Laboratories
American Meat Institute
Ames Company, Inc.,
Atlas Pharmaceutical Laboratories, Inc.,
Ayerst Laboratories
Bakers Laboratories, Inc.,
The Bayer Company, Div. of Sterling Drug Co.,
Brayten Pharmaceutical Company
George A. Breon & Co.,
Brown Hotel
Brown & Williamson Tobacco Co.,
Burroughs-Welcome & Co., Inc.,
Chicago Medical Society
Ciba Pharmaceutical Products, Inc.,
Cincinnati Sanitarium
City View Sanitarium
Clearview
The Coca Cola Company
Corn Products Sales Co.,
Crocker-Feis Company
Mr. Ernest M. Davis
J. E. Edwards, M.D.
Fairmount Hospital
Foot-So-Port Shoe Co.,
Geigy Chemical Corporation
General Electric Company
William T. Green, M.D.
John Hancock Mutual Life Ins. Co.,
The Keeley Institute
Kentucky Rehabilitation Center
Chas. B. Knox Gelatine Co.,
Lakeside Laboratories
Lederle Laboratories
Eli Lilly & Company
Louisville Heart Association
Louisville Medical-Dental Business Bureau
J. B. Lukins, M.D.,
Mead Johnson & Company
The Medical Protective Co.,
Merck, Sharp & Dohme, Inc.,
William S. Merrell Co.,
Muth Optical Company
National Drug Company
National Insurance Agency
New Castle Sanitarium
New York Polyclinic Medical School & Hosp.,
Mid-South Postgraduate Medical Assembly
Parke, Davis & Company
Pfizer Laboratories, Division of Chas. Pfizer & Co., Inc.,
The Phoenix Hotel
Physicians Casuality Association
Pleasant Grove Hospital
Professional Building Associates
Quincy X-Ray and Radium Laboratories
A. H. Robins Company
Ricker Laboratories, Inc.,
J. B. Roerig & Co.
Schering Corporation
Clayton L. Scroggins Associates
G. D. Searle & Company
Smith, Kline & French Labs.,
Southern Optical Company
E. R. Squibb & Sons
Mr. Hayward F. Spinks
State Tuberculosis Hosp. Comm.
The Training School of Vineland, N. J.
U. S. Vitamin Corp.,
The Upjohn Company
The Vaughn Clinic
Wallace Laboratories Division of Carter Products, Inc.,
Wayside Hospital
John W. Wimberly, M.D.,
White Cross Hospital
Winthrop Laboratories, Inc.,
Wyeth, Inc.,

To Our Advertisers

At this season of the year our thoughts invariably turn to all the things we have to be grateful for.

We, of the staff of The Journal of the KSMA, are most appreciative of the support of you, our advertisers, over the past twelve months.

Your patronage has made possible many improvements in our Journal and the presentation of essential medical literature to our readers.

Your advertisements have continued to grow in attractiveness and usefulness to our members.

As we look forward to making our Journal more appealing and useful to all in 1957, may we extend to each of you, our advertisers, our best wishes for the New Year.

The Editor and Staff of
The Journal of the KSMA



KARO®... meets the need for a completely assimilable carbohydrate in infant feeding

Physicians and parents alike appreciate the efficacy, convenience and economy of Karo Syrup. For this double-rich, readily miscible mixture of dextrin, maltose and dextrose is easily digested, well tolerated and completely utilized.

Three generations of use as a milk modifier have shown that even premature babies thrive on Karo... and that its use does not induce flatulence, colic, fermentation or allergy.

Karo permits easy adjustment of formula and transition from liquid to solid food as circumstances demand. It may be used with sweet, acid, evaporated, dried or protein milk. Light or dark Karo each supply equivalent nutritive and digestive values... yielding 60 calories per tablespoonful.



1906 • 50th ANNIVERSARY • 1956
CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N. Y.

IN THE BOOKS

TRANSACTIONS OF THE WESTERN SURGICAL ASSOCIATION—VOLUME 62. Recorded by Everett E. Coleman, M.D., 368 pages, illustrated. Published by The American Medical Association Press, Chicago 10, 1955.

This book contains both the executive and scientific sessions of the sixty-second annual meeting of the Western Surgical Association at Colorado Springs, Colorado, December 2, 3, 4, 1954. It represents a collection of the scientific papers that were presented at this meeting, and contains also a discussion of these papers by some of the prominent members present.

The subject matter contained in these papers covers a rather broad field of surgery, including thoracic surgery, cardiovascular surgery, and, for the most part, problems encountered by the general surgeon. There are no papers included with subject matter of interest to other surgical specialties. The papers are all well written and well illustrated. Such subjects as trauma, carcinoma, congenital, acquired and infectious diseases that are encountered by the surgeon in his daily practice are presented and discussed.

The book would be of little interest to other than a limited group of surgeons. The subject matter could be found in many of the current journals. These articles contain, however, a copious amount of reference material. The volume should make a valuable addition to a surgeon's journal library.

Henry S. Collier, M.D.

TREATMENT OF HEART DISEASE: by Harry Gross, M.D.—Abraham Jezer, M.D. Pages: 549. Publication Date: June 14, 1956. Price $13.00 W. B. Saunders Co.

This book on therapy of heart disease is a reasonably good attempt to indicate the physiologic rationale of treatment.

The book is divided in orderly fashion into seven sections, beginning with "The Basic Mechanisms of Cardiac Symptoms and Their Management," after which the therapy of specific types of heart disease is discussed. The book ends with sections dealing with the surgical, emotional, psychosomatic and rehabilitative aspects of the therapy of heart disease.

The drugs commonly used in the treatment of heart disease are well covered and specific outlines of therapy are given. Indications and contraindications for the use of various drugs and their toxic effects are clearly indicated. There is a large bibliography at the end of each chapter, but the authors seldom discuss the contents of the references in detail.

Some comments concerning therapy are not well documented either by the authors' experience or by the literature. An example is the statement that digitalis is the drug of choice in the therapy of extrasystoles "of patients with established heart disease, even in the absence of heart failure." It would seem to the reviewer that such a statement warrants documentation.

This book is an adequate desk reference for the treatment of the cardiac patient that will perhaps appeal most to the general practitioner and internist. The cardiologist may find it disappointing. The physiologic implications of therapy are not completely discussed, and the book does not represent a critical compilation of current knowledge of the therapy of heart disease. The authors do not present an analysis of extensive personal experience nor do they exhaustively review the literature.

Leonard Leight, M.D.

ELECTROCARDIOGRAPHY: FUNDAMENTALS AND CLINICAL APPLICATION. Louis Wolff, M.D., 342 pages; Publication date, March 21, 1956, W. B. Saunders Co.; Price $7.00.

The second edition of this text has incorporated the cardiac vector where indicated in a clear-cut and painless manner. The basic principles of derivation of the components of the ECG are presented in a lucid manner and the diagrammatic illustrations are well done. Many of the illustrations can be grasped even by the uninitiated without referring to the entire text. They enhance the value of the book.

The section devoted to clinical electrocardiography presents clear and useful discussions and illustrations of left and right ventricular hypertrophy. The precautions and problems of arriving at a diagnosis of right ventricular hypertrophy are particularly enlightening. The chapters dealing with myocardial infarction present this subject in a concise manner and carefully define the limitations as well as values of the ECG. The illustrative reproductions of ECGs are of high quality and the changes under discussion are easily seen.

The section on the cardiac arrhythmias is a new addition to the book. It is not presented with the clarity necessary to make these mechanisms readily understood. This section will probably be revised in time and come up to the high standards exemplified in other sections.

This book is a good one as are several other texts on the subject. It is not essential if one has available other modern texts on electrocardiography but the internist or other practitioner particularly interested in the subject will find it informative. No bibliography is incorporated into the book.

Ralph M. Denham, M.D.

HANDBOOK OF PHYSICAL THERAPY. Shestack, Robert. Published by Springer Publishing Company, Inc., New York, 1956; 212 pages; Price $4.25.

This book is a fairly well-organized presentation of a great volume of limited material. The statements are all general statements and are not specific. The terminology is non-scientific. The only part of which are acceptable, are most of the technics described. However, even in technic of application one finds incomplete description.

A description of the field about which this book is written is erroneous. I wish to point out on page 3 the use of the term physical therapy and physical medicine as synonymous terms is completely erroneous. Physical therapy is just one branch of the field of physical medicine.

In the Preface on page X the author states that the reader will find nothing concerning rehabilitation technics, and the whole book deals with rehabilitation technics. In spite of the thirty-nine outstanding references in the bibliography of this book, there are no specific referral situations in the text, and, when dealing with physiological effects of certain physical agents, there are many erroneous statements that are stated as fact.

Because of the limitation of the scope of this book, it is possible to leave the impression that this had come through the entire field of physical therapy, which it does not.

Because of the above-mentioned discrepancies in this book, I would not recommend it for the use of medical students, or the student of physical therapy, or the practicing physical therapist.

Rex O. McMorris, M.D.

Symptomatic relief...plus!



Achrocidin*

Tetracycline-Antihistamine-Analgesic Compound

ACHROCIDIN is a comprehensive formula for treatment of complications of the common cold, particularly when bacterial sequelae are observed or expected from the patient's history or during widespread infections.

Distressing symptoms of malaise, headache, muscular pain, mucosal and nasal discharge are rapidly relieved.

And potent prophylaxis is offered against other diseases, such as otitis media, sinusitis, adenitis, and bronchitis, to which the patient may be highly vulnerable at this time.

ACHROCIDIN is convenient for you to prescribe—easy for the patient to take. Average adult dose: two tablets four times daily.

Available on prescription only

Each tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottle of 24 tablets

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N. Y.

*TRADEMARK

relaxes both mind and muscle

for the average patient in everyday practice

- well suited for prolonged therapy
- well tolerated, nonaddictive, essentially nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

Indications: **anxiety and tension states, muscle spasm.**

THE ORIGINAL MEPROBAMATE®

Miltown®

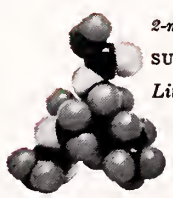
Tranquilizer with muscle-relaxant action

DISCOVERED AND INTRODUCED BY WALLACE LABORATORIES, *New Brunswick, N.J.*

2-methyl-2-n-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720

SUPPLIED: *400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.*

Literature and Samples Available on Request

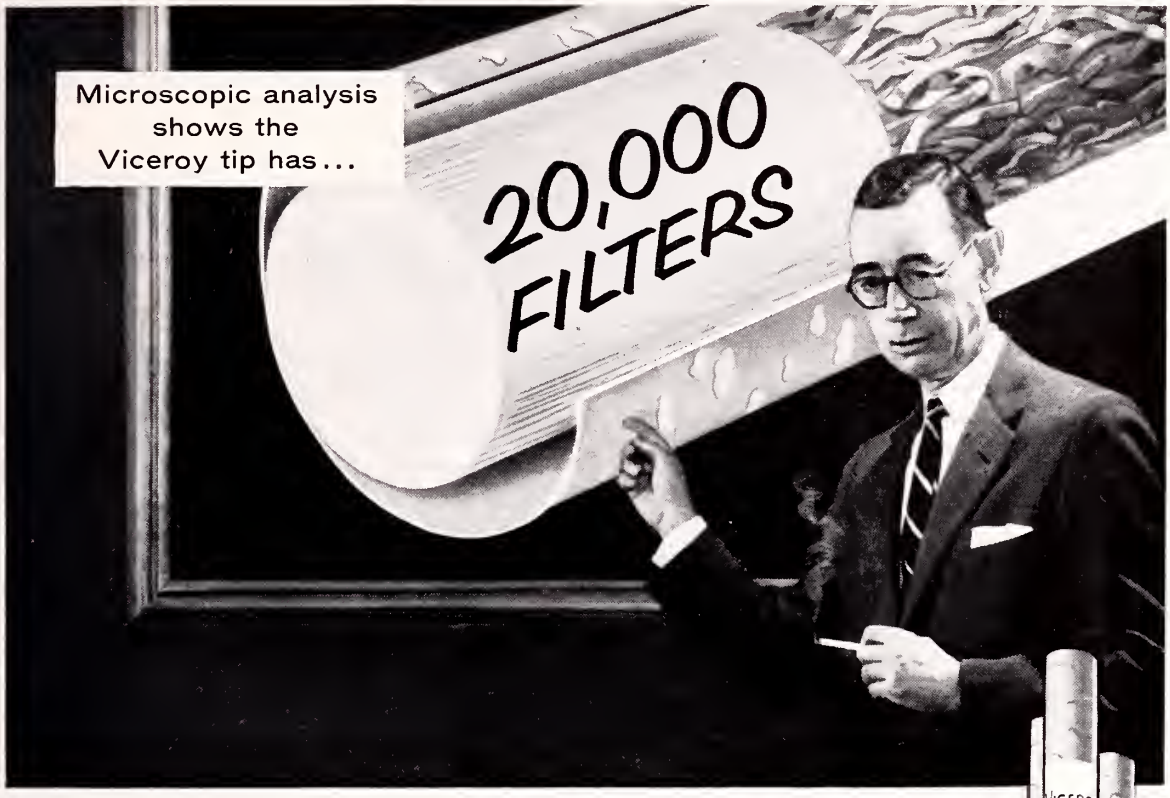


THE MILTOWN MOLECULE

CM-3706-R2

HERE'S WHY SO MANY DOCTORS NOW SMOKE AND RECOMMEND

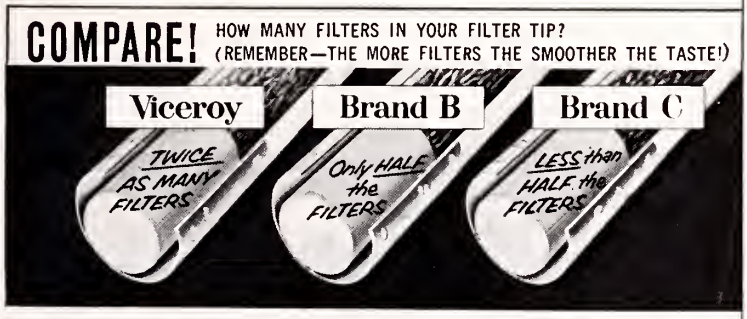
VICEROY



Twice as Many Filters

AS THE OTHER TWO LARGEST-SELLING FILTER BRANDS

For the Smoothest Taste in Smoking!



VICEROY'S EXCLUSIVE FILTER IS MADE FROM PURE CELLULOSE—SOFT, SNOW-WHITE, NATURAL!





WASHINGTON NEWS DIGEST



Washington, D. C.—Federal health and medical spending for all agencies of government this fiscal year is expected to reach a new high peak. The total is placed at $2,558,719,168, an increase of nearly 13 per cent over the last fiscal year, which itself set a new record.

The spending is spread among 21 departments, agencies and commissions concerned in whole or part with health or medicine. They range from an impressive $825,024,300 for the Veterans Administration to a small sum of $12,145 for running the Office of the Attending Physician of Congress.

In between is a broad range of health and medical activities, including money for implementing the many health programs inaugurated by the 84th Congress. The totals are compiled each year by the American Medical Association's Washington Office. The report, the only consolidated Federal medical budget published, is based on actual appropriations by Congress and program data supplied by the federal agencies.

The medical budget total, divided into cost for each man, woman and child in the country, amounts to $15.17 a year, while each family in the U. S. will be paying $54.61 for this spending, based on Census Bureau figures for population, family size and employment.

Compared with last year's spending, the Defense Department has dropped to second place with its spending estimated at $790,105,000, thus giving way to the VA. The Defense Department shift from the top spending spot, despite a $41 million item for the new dependent's medical care program, is due primarily to more effective joint utilization of facilities, fewer personnel assigned to operation and a planned drop in hospital and dispensary construction.

Department of Health, Education, and Welfare spending for the year ending next July 1 amounts to $772,661,800, which puts that agency's total within striking distance of the two top spenders in the health-medical field. Compared with last year's $526,935,400, HEW spending this year is up a resounding 46 per cent, due in part to more Hill-Burton hospital construction money, record research funds, and permanent and total disability payments.

Following is a table of spending by the 21 agencies this year and last:

Agency	Fiscal 1957	Fiscal 1956
Veterans' Administration	$ 825,024,300	$ 790,185,800
Department of Defense	790,105,000	818,104,500
Department of Health, Education and Welfare	772,661,800	526,935,400
Federal Civil Defense Admin.	49,810,000	30,450,000
Atomic Energy Commission	31,525,000	27,700,000
International Cooperation Admin.	29,310,000	25,441,000
Department of State	15,496,000	13,669,790
Federal Employees Health Program	10,000,000	6,000,000
National Science Foundation	8,000,000	5,000,000
Department of Labor	7,151,126	7,336,000
Department of Interior	6,138,205	5,770,000
Panama Canal Zone	6,055,300	5,702,900
Department of Treasury	3,511,700	2,990,000
Department of Justice	1,580,000	1,470,000
Federal Trade Commission	1,000,000	1,000,000
Department of Commerce	547,914	277,586
Civil Service Commission	386,000	382,600
National Advisory Committee to Selective Service	180,000	180,000
President's Comm. for Handicapped	134,678	130,000
Health Resources Advisory Comm.	90,000	101,000
Office of Attending Physician of Congress	12,145	------
TOTALS	$2,558,719,168	$2,268,826,576

NOTES:

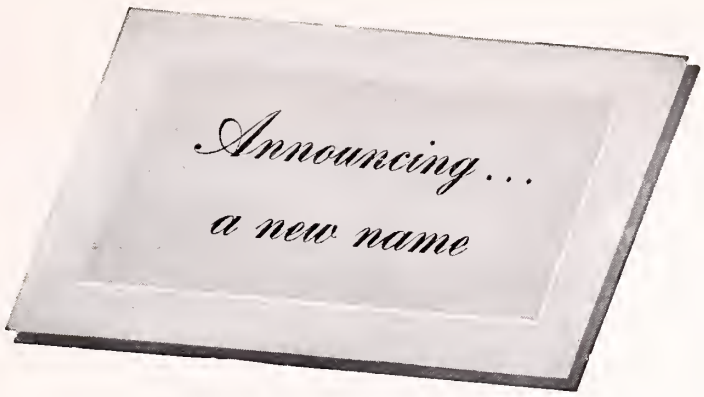
The long-awaited military dependents' medical care program authorized by the last Congress went into effect December 7. At the height of the program, as many as 800,000 persons not now getting care are expected to be receiving treatment either at military facilities or through private physicians and hospitals. It was launched following a series of negotiations with state medical societies over contracts covering the provision of care outside military hospitals and clinics.

* * *

Dr. Leroy E. Burney, PHS surgeon general since last August, has announced a number of shifts in major posts within the service. They include Dr. John Cronin, chief of the Hill-Burton program, to head the important Bureau of Medical Services; Dr. Jack Masur, from this bureau to directorship of the Clinical Center of Bethesda, Md.; Dr. G. Halsey Hunt, associate chief of the bureau, to a new Center for Research of Aging at National Institutes of Health; Dr. Donald W. Patrick from the Clinical Center to PHS hospital at San Francisco; Dr. Vane M. Hoge, from associate chief of the bureau to Hill-Burton.

* * *

With the death of Rep. Percy Priest of Tennessee and the election of a Democratic House, Rep. Oren Harris, Democrat, of Arizona, assumes chairmanship of the important House Interstate and Foreign Commerce Committee. It handles most health legislation in the House. The companion Senate Committee on Labor and Welfare again will be headed by Senator Lister Hill (D., Ala.).



'LANOXIN'
brand
DIGOXIN

formerly known as Digoxin 'B. W. & Co.'®

The new name has been adopted
to make easier for everyone
the distinction between
Digoxin and Digitoxin.

Now simply write: 'Lanoxin' Tablets 0.25 mg. or 0.5 mg.
'Lanoxin' Elixir Pediatric, or
'Lanoxin' Injection

to provide the unchanging safety and predictability afforded by the uniform potency, uniform absorption, brief latent period and optimum rate of elimination of this crystalline glycoside.

Tablets:	*0.25 mg. (white) and 0.5 mg. (green)*
Elixir Pediatric:	*0.05 mg. in each cc.*
Ampuls:	*0.5 mg. in 2 cc.*

BURROUGHS WELLCOME & CO. (U.S.A.) INC., *Tuckahoe, New York*

Upjohn

Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

Cortef* *tablets*

Supplied:

5 mg. tablets in bottles of 50
10 mg. tablets in bottles of 25, 100, 500
20 mg. tablets in bottles of 25, 100, 500

*REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF HYDROCORTISONE (COMPOUND F)

The Upjohn Company, Kalamazoo, Michigan



PLAN TO ATTEND

February 1 & 2, 1957

3rd Annual Symposium on Cardiovascular Diseases

ROOF GARDEN — BROWN HOTEL

LOUISVILLE, KENTUCKY

Guest Speakers Include These Doctors—

"Dietary Management of Atherosclerosis"
MAURICE M. BEST, M.D., Assistant Professor of Medicine, University of Louisville School of Medicine

"The Basis of the Electrocardiogram"
ROBERT C. LITTLE, M.D., Director of Clinical Research, Mead Johnson & Company

"Occlusion and Aneurysm of the Abdominal Aorta"
EDGAR V. ALLEN, M.D., Senior Consultant, Mayo Clinic, President American Heart Association

"The Surgical Treatment of Congenital and Acquired Heart Lesions by Open Cardiotomy"
C. WALTON LILLEHEI, M.D., Professor, Department of Surgery, University of Minnesota Medical School

"Presbycardia"
HUGH J. MORGAN, M.D., Professor, Head of Department of Medicine, Vanderbilt University School of Medicine

"The Use of Bi-Plane High Speed Selective Angiocardiography in the Diagnosis of Congenital Heart Disease"
LAWRENCE A. DAVIS, M.D., Associate Professor of Radiology University of Louisville School of Medicine

"Acute Coronary Insufficiency; Differential Diagnosis and Treatment"
ARTHUR M. MASTER, M.D., Associate Professor of Medicine, Columbia University College of Physicians and Surgeons

"Surgery of Peripheral Vascular Disease"
MICHAEL E. DEBAKEY, M.D., Professor and Head of Department of Surgery, Baylor University College of Medicine

"Hemodynamic Responses to Life Stress"
STEWART WOLF, M.D., Professor and Head of Department of Medicine, University of Oklahoma School of Medicine

REGISRATION $5.00 PER DAY

12 Credit Hours Allowed by American Academy of General Practice

Sponsored by The Heart Association of Louisville and Jefferson County and University of Louisville School of Medicine.

a new maximum
in therapeutic
effectiveness

a new maximum
in protection
against
resistance

a new maximum
in safety and
toleration

multi-spectrum
synergistically
strengthened...

fo
you
entir



Sigma

OLEANDOMYCIN TETRACYCLINE



atient
opulation

mycin*

a new certainty
in antibiotic therapy,
particularly for
the 90% of patients
treated at home
and in the office

Superior control of infectious diseases through superior control of the changing microbial population is now available in a new formulation of tetracycline, outstanding broad-spectrum antibiotic, with oleandomycin, Pfizer-discovered new antimicrobial agent which controls resistant strains. The synergistic combination now brings to antibiotic therapy: (1) a new fuller antimicrobial spectrum which includes even "resistant" staphylococci; (2) new superior protection against emergence of *new* resistant strains; (3) new superior safety and toleration.

*TRADEMARK

Pfizer

NEW

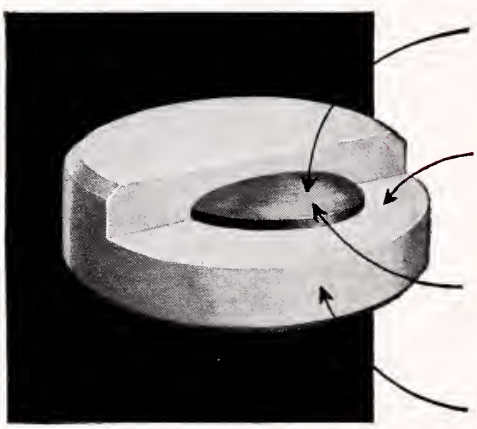
For Pain-Free
of everyday
In "Rheumatism"*

Multiple

TEMP

combine:

THE PROPER FORMULA
PROPERLY FORMULATED



Physical separation of the steroid component from the aluminum hydroxide as provided by the Multiple Compressed Tablet construction assures full potency and stability of prednisolone.

PREDNISOLONE (*1 mg.*)
+
ASPIRIN (*0.3 Gm.*).....
+
ASCORBIC ACID (*50 mg.*
+
ANTACID (*0.2 Gm.*).....

*Early rheumatoid arthritis
Rheumatoid spondylitis
Osteoarthritis
Still's disease
Psoriatic arthritis
Bursitis
Synovitis
Tenosynovitis
Myositis
Fibrositis
Neuritis

Performance

ctivities

Patients



ompressed Tablets

OGEN®

..... for anti-inflammatory, anti-rheumatic benefits *at effective low dosage.*

..... for analgesia plus additional anti-rheumatic activity.

..... for anti-stress support that guards against adrenal ascorbic acid depletion.
(Ascorbic Acid present as 60 mg. Sodium Ascorbate.)

..... dried aluminum hydroxide gel minimizes the possibility of gastric distress.

DOSAGE: *1-4 TEMPOGEN Tablets t.i.d. or q.i.d. (TEMPOGEN Forte, 1 or 2 tablets t.i.d. or q.i.d.) for one or two weeks. Then lower by 1 tablet every four or five days to maintenance level.*

SUPPLIED: *TEMPOGEN and TEMPOGEN Forte —in bottles of 100 Multiple Compressed Tablets. (TEMPOGEN Forte provides 2 mg. of prednisolone.)*

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

"You try to scrub the bathtub with your back aching morning till night!"

"I don't know about bathtubs, but two days ago I couldn't reach a shelf higher than that."

"I thought maybe I slept in a draft. Never had a stiff neck like this before."

"That's nothing. I went around with my arm in a sling for nearly two weeks—had to sleep with a pillow at my back so I wouldn't roll over on it."

"I thought I was getting too old for high heels—low heels didn't help. My leg hurt down to the ankle."

"That's funn I'm on my feet all day but it was my arms th bothered m



. . . safeguarded relief all the way across thes

Prednisone + Acetylsalicylic Acid + Aluminum Hydroxide + Ascorbic Acid: Potent corticosteroid anti-inflammatory action complemented by rapid analgesia; doubly protected with antacid and supplemental vitamin C.

"My back was so tight I couldn't even get on and off the bus; now I can climb stairs."

"I hope he helps my knee that quick."

"Take it from me, you should be glad you saw him early in the game so he could do some good."

"Good?— why, he's got me doing exercises I haven't done in years."



spread of common rheumatic complaints

Summated, protective corticoid-analgesic therapy

SIGMAGEN*

corticoid-analgesic compound tablets

- brings specific, complementary benefits to the treatment of muscle, ligament, tendon, bursa and nerve inflammation
- for the initiation of treatment of milder rheumatic disease
- for continuous or intermittent maintenance in more severe rheumatic involvement

Bottles of 100 and 1000.

Schering

prevents postpartum hemorrhage
speeds uterine involution



'Ergotrate Maleate'

(ERGONOVINE MALEATE, LILLY)

. . . produces rapid and sustained contraction of the postpartum uterus

'Ergotrate Maleate' almost completely eliminates the incidence of postpartum hemorrhage due to uterine atony. Administered during the puerperium, 'Ergotrate Maleate' increases the rate, extent, and regularity of uterine involution; decreases the amount and sanguineous character of the lochia; and decreases puerperal morbidity due to uterine infection.

Supplied:

Ampoules of 0.2 mg. in 1 cc.
Tablets of 0.2 mg.

DOSAGE: Generally, 0.2 to 0.4 mg. I.V. or I.M. immediately following delivery of placenta. Thereafter, 0.2 to 0.4 mg. three or four times daily for two weeks.

80TH ANNIVERSARY 1876 · 1956 / ELI LILLY AND COMPANY

659004

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 54 DECEMBER, 1956 NO. 12

THE SELECTION OF PATIENTS FOR RADICAL MASTECTOMY

GEORGE B. SANDERS, M.D.
DAVID W. KINNAIRD, M.D.
Louisville

THE SURGEON operating on breast cancer bases the logic of his efforts on the principle of a large operation for a small cancer. By so doing, he hopes to get all of the cancer out, that is, literally 100 per cent of the cancer cells, and achieve a permanent cure for his patient. Failing this, he hopes to get perhaps 90 per cent of the cancer cells out, and leave only small deposits which are amenable to long term control. He also hopes, very fervently, to avoid inflicting an extensive, debilitating, costly and mutilating operation upon a patient that he is powerless to help.

Sixty-five years of indiscriminate radical mastectomy for all comers with breast cancer

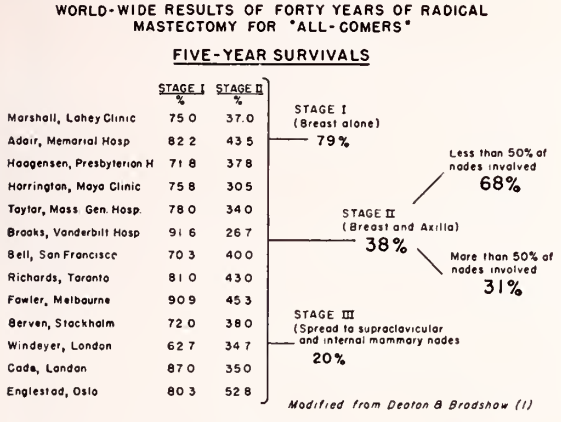


FIGURE 1

in all stages of the disease has taught us several very valuable lessons. First of all, we now know that any operation, no matter how radical, for the cure of breast cancer, is effective only when it is applied against the disease in its early stages, when the cancer is limited to the breast or to the breast and axilla. (1) (Figure 1) Secondly, from long term studies of the material removed by radical mastectomy correlated with clinical findings and extended followups in literally thousands of cases, we now know how extensive the operation must be in order to have any hope at all of getting all the cancer out, even when the operation is applied against the disease in these early stages.

Selection of Cases

There is little argument that a competent radical mastectomy is highly efficient in extirpating cancer limited to the breast alone. The controversy rages about the Stage II cases in which the cancer has spread to the axilla. In general, three points of view are held today.

(1) Axillary invasion by cancer spells surgical failure. Operations designed to remove cancer with axillary invasion are therefore impractical.

(2) Axillary spread requires for its removal and possible cure an operation with a greater scope than the classical radical mastectomy, and one which will successfully remove cancer deposits in the next echelons of cancer spread beyond the axilla, namely the supraclavicular fossa, mediastinum and internal mammary lymphnode chain. Such operations have been devised by Wangensteen and Urban. (2) (3)

(3) The third viewpoint, one which we have chosen to adopt, maintains that axillary invasion by cancer does not necessarily prophesy failure to cure by radical mastectomy. It asserts that a certain group of patients with axillary invasion, if not too extensive, can be salvaged by means of a very complete, thorough and extensive mastectomy technic, which has evolved as the result of many years' observation

*From the Department of Surgery, University of Louisville School of Medicine and the Surgical Service, Norton Memorial Infirmary.

of the limits of spread of breast cancer on the surface of the thoracic cage beneath the clavicle. (8) (13) (Figure 2)

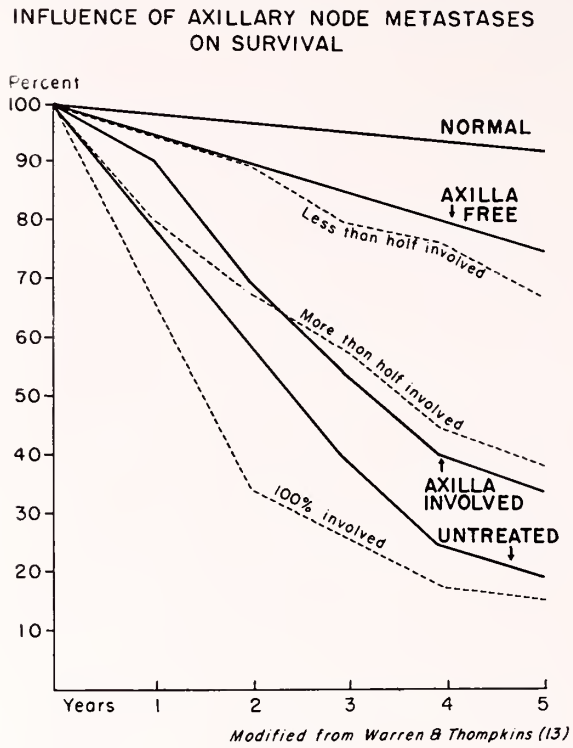
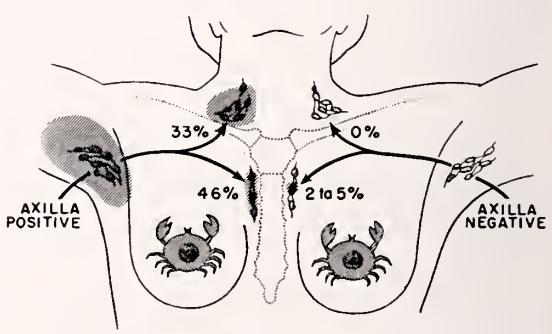


FIGURE 2

The operation that has been thus developed is truly a formidable one, requiring several hours of steady, backbreaking work, at nearly top speed, the loss and replacement of three or four pints of blood, and usually requires a skin grafting procedure for closure of the defect. It is much more extensive and complete than the average radical mastectomy as originally conceived by Halsted and Meyer. It has been adequately described by Haagensen. (4) It is an unpopular operation with the patient, the patient's family, the family physician, and with the operating room nurses, interns and surgical residents who have to stand for several hours at a dull, repetitious task. It is likely to be unpopular with the busy community surgeon whose schedule it disrupts completely during that operative day. However, it stands the best chance of consistently getting all or most of the cancer out, in properly selected cases. When, however, it is applied unwisely to more advanced cases and becomes thereby an incomplete cancer operation, the ill effects on the patient are as great as, if not greater than, those of the average radical mastectomy on Stage III or IV breast cancer.

For these reasons, it is imperative that a workable means of estimating the extent to which a given breast cancer has spread, relative to the scope of the operation designed to remove it, be developed for the selection of patients suitable for this very extensive operation. Heretofore, such selection has been based purely on clinical evaluation of the extent of disease, which is notoriously fallible. One has only to reflect upon the inaccuracy of clinical prediction of axillary involvement alone to realize this fact. Methods of evaluation have culminated in the elaborate criteria of operability formulated by Haagensen. (5) (6) (7) These, with some modification, have stood the test of time and experience in several large clinics. During the past thirteen years, however, the human material coming to the hands of surgeons has altered significantly so that ever-increasing numbers of patients come early to the surgeon with breast cancers exhibiting few, if any, of the clinical manifestations useful in evaluating the extent of the disease by Haagensen's criteria. Nevertheless, many of these apparently early lesions have already metastasized, and will fail to be cured by even the most extensive and complete mastectomy. One has only to reflect on the sad fact that 28 per cent of lesions with a diameter of 10 mm. or less are said to have already metastasized to the axilla. (7) A lesion of this size is barely perceptible by clinical examination, and in many patients of robust nutrition is not detectable, and is often found only by accident.

Experience has taught us that the gloomy significance of the heavily involved axilla lies, not in its contained cancer which we feel confident to extirpate by a careful, thorough surgical procedure, but to the increasing likelihood of cancer-escape beyond the axilla to depots in the supraclavicular fossa, internal mammary



Frequency of metastases to supraclavicular and internal mammary lymph nodes based on axillary involvement.

FIGURE 3

chain, and mediastinum. Hematogenous spread to distant foci which we are at present unable to detect in its early stages, is another important cause of failure in otherwise favorable-appearing lesions.

It is known that the two carliest areas of lymphogenous spread beyond the axilla are the homolateral supraclavicular fossa and internal mammary chain. (8) (9) (10) (11) (Figure 3) An interesting correlation between the extensiveness of axillary involvement and the percentage frequency of internal mammary chain spread can be seen by reference to Figure 4.

RELATION OF DEGREE OF AXILLARY INVOLVEMENT TO INTERNAL MAMMARY INVASION (146 cases)

Extent of Axillary Involvement	No of Cases	Cases with Internal Mammary Invasion	
0 *(free)*	57	8	*(14%)*
1 *(light)*	23	6	*(26%)*
2 *(moderate)*	32	12	*(37%)*
3 *(heavy)*	34	22	*(65%)*

from Handley and Thackray (12)

FIGURE 4

(12) A comparable correlation for the involvement of the supraclavicular fossa is not available but we do know that it is not invaded in the absence of axillary involvement and that when the apex or high point of the axilla is involved, the incidence of supraclavicular fossa invasion is extremely high. With even the very extensive radical mastectomy that we advocate, these deposits of cancer will remain untouched and the operation will thereby become a grossly incomplete cancer operation. It would, therefore, seem logical first to sample these important secondary areas of spread before committing any patient to an extensive operation for cure.

Triple Biopsy

Because of the very nature of cancer operations in general, we are not permitted to explore the axilla in order to find out the extent of axillary invasion. Indeed, such information, even were it available, would not be as valuable as the information gleaned from sampling extra-axillary echelons of spread, so long as we do not, as yet, have any clinical and pathological correlations of degree of local spread with frequency of hematogenous dissemination. Such a technique for sampling these areas is called "triple biopsy" and was devised by Dr. Cushman D. Haagensen of New York City several years ago. (14) Four years ago, following conversations with Dr. Haagensen, and after one or two particularly unhappy episodes with early, but incurable, breast cancers, we decided to adopt this method as a technique for evaluating most patients with breast cancer, as to their suitability for an extremely complete and extensive radical mastectomy for cure.

Briefly, the sequence of operative events is as follows:

(1) Careful, gentle biopsy of the primary site in the breast, removing only a wafer slice of the lesion, unless the lesion is less than 1 cm. in diameter. If grossly positive, the biopsy site is cauterized, meticulously closed with complete hemostasis and sealed. If any doubt exists as to the presence of cancer, a quick frozen section is resorted to.

(2) Next, with a fresh set-up of instruments, gowns, gloves, drapes, etc., a vertical incision is made over the first three homolateral interspaces, about one fingerbreadth from the sternum, and the contents of the first three interspaces are completely removed and sent to the laboratory for paraffin section. The lymph-nodes in these spaces are inconstant in location and exceedingly small and must be searched for diligently. Quick frozen section is not accurate enough for the study of this tissue.

(3) If no gross cancer is found in the interspaces the incision is meticulously closed and sealed and a transverse incision is made over the inner third of the homolateral clavicle. Formerly we explored the supraclavicular fossa and evacuated its contents, sending all tissue to the laboratory for study. Lately, as a result of conversations with Dr. Haagensen, we have followed his lead in exploring the high point of the axilla instead and securing the one or two subclavicular nodes (Halsted's nodes) in close relationship to the axillary vein as it dips beneath the clavicle. These and adjacent areolar and fatty tissue are likewise sent to the laboratory for study. Quick frozen section is not considered suitable. If gross cancer is found in the interspaces, the subclavicular portion of the triple biopsy is not deemed necessary.

(4) In addition to the triple biopsy outlined above, we have, for the past four years, been supplementing this with a bone marrow biopsy obtained from the homolateral iliac crest

preferably after the manner of Hyman and for the reasons set forth in his paper. (14)

The patient is then returned to her ward and results of the studies are awaited. The information from bone marrow biopsy is available in a few minutes, that from the other biopsies is usually available in 24 hours.

It is apparent that a drastic deviation from accepted ideal techniques of biopsy and immediate radical surgery has taken place, in that a short interval, usually not exceeding 24 hours, is deliberately permitted to elapse between biopsy and the performance of the radical operation for cure. This interval is necessitated by two factors. First, the triple biopsy itself takes from 45 to 95 minutes to complete. We do not feel that it is wise to add this additional time to an extensive radical operation to follow, which will take from four to six hours to complete. Secondly, accurate information, which is, after all, what we are seeking, depends on the use of permanent sections for the study of the lymphnode biopsies. This requires at least 24 hours' wait. There is, perhaps, a theoretic disadvantage in disturbing a cancer in its bed and allowing so much time to elapse before removing it by a curative operation. By the gentleness and carefulness of our biopsy technique, we attempt to minimize such disturbance. In addition, available statistical evidence fails to show any adverse effect on the prognosis of patients with breast cancer of intervals of less than two weeks between biopsy and a conscientious radical operation for cure. (15)

Objections may be raised on the grounds of psychological and physiological ill-effects of two operating seances. With modern anesthesiology and surgical techniques, the physiological effects are negligible. Experience with our patients over a period of five years has convinced us that the psychological effects are not adverse, and rather, that patients and relatives welcome the chance to discuss at length with the surgeon the findings of the biopsies and what form the treatment will take. The reassurance to the patient provided by the knowledge that cancer has not been found in distant nodes is not negligible. It has seemed to us that the shock of discovering that one has breast cancer is less severe when one makes that discovery with both breasts still intact and in a relatively comfortable environment than when the patient awakes many hours postoperatively to find as her first indication that she has cancer, that one breast and a portion of her chest wall are painfully missing. It has also seemed to us that the emotional reaction of the loss of the breast has been far less after the opportunity granted by triple biopsy to inform the patient carefully, kindly and completely of the facts at hand and of the necessity for certain drastic forms of treatment.

Indications for Triple Biopsy

Obviously all patients need not be subjected to triple biopsy, although as our experience has grown, we have tended more and more to subject most patients with breast cancer to this procedure. Our present indications for triple biopsy are as follows:

I. Location
   A. Inner Hemisphere
   B. Central Sector
II. Duration—Two Months or More, or Indefinite Age
III. Size—More than 3 cm. diameter
IV. Extent—Clinically Suspicious Axillary Nodes, Edema of Skin, Dimpling of Skin, Nipple Retraction and Deviation, Etc.
V. Delay—Of Two Weeks or More Since Biopsy of Primary Site
VI. Bilateral Lesions
VII. Tumors Arising during Pregnancy or Lactation

The interpretation of the findings obtained by this technique of multiple sampling is highly important. We have felt that patients showing invasion of either the supraclavicular fossa, Halsted's nodes or the internal mammary chain are unsuitable for radical mastectomy. We have not yet adopted any of the superradical procedures devised by Wangensteen and Urban, since we cannot be convinced that they are curative operations. As community surgeons, we are reluctant to inflict such operations upon our patients without having proof that they are effective. In the case of bone marrow biopsy, if the findings are strongly positive with clumps of unmistakable cancer cells, we are inclined to consider the patient unsuitable for radical mastectomy. In the face of well known difficulties in interpreting abnormal cells in bone marrow preparations, however, we feel justified in accepting for radical mastectomy those patients who have an equivocally

positive bone marrow but whose triple biopsy is otherwise negative.

Failure to consider a patient suitable for ultra-radical mastectomy does not imply in our minds that the patient is unsuitable for surgery or that the patient should be denied extensive and vigorous treatment. Such patients unsuitable for ultra-radical mastectomy may well and logically become candidates for simple mastectomy to be followed by intensive x-ray therapy and subsequently by other methods of inhibiting or delaying cancer growth by hormonal alteration, chemo-therapy, and the like. Thus, the old fatalistic attitude of considering hopeless patients who are not subjected to radical mastectomy we feel is thereby largely avoided, and we do tend to treat these patients surgically, vigorously and extensively, with, we think, more logic and effectiveness than a policy of indiscriminate radical mastectomy for all comers.

Data of Seven-Year Study

Our results with the treatment of breast cancer by means of an ultra-radical mastectomy cover a period of seven years and are not statistically significant. It is not possible from the following figures to discern any definite trends of statistical significance. Mastectomies of lesser scope than the ultra-radical technique described by Haagensen have not been employed. In only one instance has skin grafting not been a part of the radical mastectomy technique. All cases included in these studies are from our private practice. The following tables present the material and the background for the present study which is continuing. We hope to have supplementary information of interest and value in an additional five years.

I. Material
- Total cases of breast cancer receiving treatment at our hands 50
- Follow-up ..... 100% traced
- Bilateral primary cancer .. 5
  - Simultaneous 3
  - Consecutive 2

II. Evaluation
- X-ray survey and biopsy of primary site 19
- X-ray survey, biopsy of primary site, and bone marrow biopsy 1
- X-ray survey, biopsy of primary site, and internal mammary node biopsy 3
- X-ray survey, triple biopsy, and bone marrow biopsy 27
- Primary x-ray survey
  - Negative 49
  - Positive 1
- Triple biopsy
  - Negative 21
  - Positive (All Internal Mammary) .. 5
- Bone marrow biopsy
  - Negative 24
  - Positive 1
  - Negative in face of positive x-ray survey 2
  - Positive in face of negative x-ray survey 1
- Failure to find internal mammary nodes as such 1
- Failure to find Halsted's nodes as such 1

III. Treatment
- Treated by X-ray Therapy (plus Bilateral Oophorectomy) 1
- Treated Surgically 49
- Radical Mastectomy 34
  - Unilateral 23
  - Simultaneous Bilateral Radical 2
  - Urban Type 2
  - Sugarbaker Type 1
  - Pack Bilateral Mastectomy (Unilateral Radical) 6
- Simple Mastectomy 15
  - For Cure (Without X-ray Therapy) 8
  - For Palliation 7
    - Advanced Age (98) .. 1
    - Advanced Age (79) and Medical Contraindications 1
    - Advanced Cancer 5

  (Post-operative X-ray Therapy Given)
- Operative Mortality 0

IV. Results
- Deaths
  - After Radical Mastectomy for Cure 6
    - Duration of Life from Onset to Death (Average) 44 months
  - After X-ray and Oophorectomy... 1
    - Duration of Life from Onset to Death .....28 months
  - (Average Duration of Life from

Onset to Death in Untreated Cases ..... 39 months) (Daland, Lazarus-Barlow)[16, 17]	
Deaths after Simple Mastectomy for Palliation	1
Deaths after Simple Mastectomy for Cure	0
Total Deaths from Cancer	8

Discussion

As stated previously, none of the data in the foregoing tables is statistically significant. It is of interest that we have at present four so-called "five year survivors." Of these, one is alive and well at five and one-half years, with no evidence whatsoever of cancer. She originally had a simultaneous bilateral radical mastectomy for simultaneously occurring bilateral primary breast cancers of small size. The axillas were uninvolved by cancer. Three other patients have died of their cancers at five and one-half, six and seven years postoperatively, an indication of the futility of adopting five-year survival as a measuring stick. The absence of mortality with this very large operation has been gratifying. Morbidity due to delayed healing, flap necrosis, etc., has been reduced gratifyingly by the adoption of continuous suction drainage and avoidance of external pressure dressings.

Local recurrence has occurred in only two patients, in each of whom a compromise with ideal principles of cancer surgery occurred. The first had a simple mastectomy in which cancer was found in the specimen. This was followed 48 hours later by a radical mastectomy. The second patient had had a somewhat mutilating biopsy done elsewhere three weeks prior to radical mastectomy at our hands.

Enough of our cases have survived sufficient years following mastectomy without local recurrence to give us convincing evidence that local dissemination of cancer caused by the technique of triple biopsy and the short interval between biopsy and radical operation, has not occurred.

Five patients with internal mammary nodes positive for cancer are interesting. In the first of these, quick frozen section of the internal mammary node in the second interspace was reported erroneously as negative and a radical mastectomy followed immediately. This patient is alive and well 28 months after radical mastectomy, with no evidence of recurrent or residual cancer. The second patient with known internal mammary node spread had an Urban type extended radical mastectomy for cure. Although we suspect that residual cancer is present and is probably contributing to fairly severe lymphedema of the arm, nevertheless she is alive, active and well with no definite proof of residual cancer at 42 months after operation. The third patient underwent a bilateral simple mastectomy after cancer had been found post partum in the breast and internal mammary chain of one side. This was followed almost immediately by extensive super-voltage rotational scanning x-ray therapy and she is alive and well without clinical proof of recurrent or residual cancer at 44 months after operation. The fourth patient with internal mammary metastasis was subjected to a simple mastectomy and intensive postoperative x-ray therapy after the McWhirter technique. Although she had an advanced local cancer, she is alive, active and well, with no evidence of residual disease 24 months after operation. The fifth patient with internal mammary cancer involvement presented a two-month-old, perfectly mobile somewhat bulky lesion in the central sector of the left breast. By all clinical criteria this should have been an operable breast cancer, suitable for radical mastectomy. Her x-ray survey and bone marrow biopsy were negative. Triple biopsy, however, revealed heavy involvement in the second interspace, and a simple mastectomy was performed, with intensive x-ray therapy of both internal mammary chains, the chest wall and the homolateral supraclavicular fossa following. The patient has been operated upon too recently for any conclusions to be drawn.

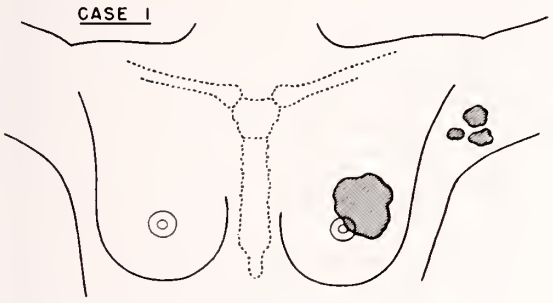
The single patient with an unequivocally positive bone marrow biopsy is also interesting. Although she had clinically far advanced local extension of cancer, nevertheless, the very careful and extensive x-ray survey was entirely negative for metastatic disease. Following the demonstration of cancer by bone marrow biopsy, she was treated by simple mastectomy, followed by intensive postoperative x-ray therapy. She is alive and well 19 months after operation with the only evidence of residual cancer being a solitary metastasis to the left hip which has responded well and is now completely controlled by x-ray therapy.

Five Unusual Cases

Triple biopsy, plus bone marrow biopsy, has been particularly helpful to us in a small series of unusual or complicated cases of breast cancer which will be described briefly:

Case No. 1—H.S. Age 55

Slowly growing mass in upper and outer quadrant of left breast, seven years, with recent skin dimpling and development of axillary nodes. Clinically, a Haagensen inoperable case, although exhaustive x-ray survey was entirely negative and patient was in excellent general health. (Figure 5)



- Large semifixed mass in upper-outer quadrant present 7 years; recent (2 months) axillary lymph node enlargement, three axillary nodes 3, 5 and 1.5 cm.
- Bone Marrow biopsy POSITIVE Triple biopsy not done

FIGURE 5

Problem: Although large, tumor obviously slow growing (seven years) with only recent evidence of axillary invasion, indicating a tumor reluctant to metastasize. Could cancerous mass be completely removed physically by radical mastectomy?

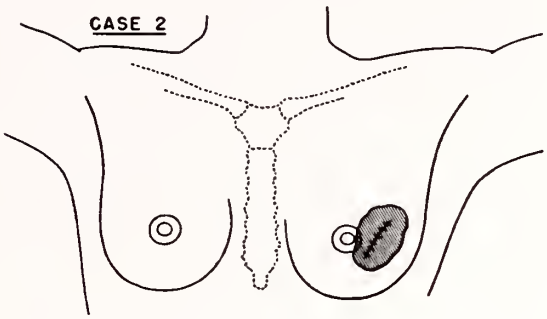
Evaluation: Bone marrow biopsy revealed malignant cells.

Treatment: Careful, complete, extensive simple mastectomy, including the more prominent, enlarged axillary nodes easily available, followed by immediate intensive x-ray therapy.

Course: Developed solitary metastasis to left hip two years after operation, which has responded in excellent fashion to x-ray therapy. Patient is alive, well and active two and one-third years after surgery, and apparently, nine and one-third years after the beginning of the cancer.

Case No. 2—V.W. Age 48

Lump in upper and outer quadrant, left breast, for four months. Biopsied elsewhere three weeks previously. Study of biopsy sections suggested that the edge only of the cancer had been cut into and that most of the primary remained. Widespread induration around biopsy site indicated undesirable technique and possible local spread of cancer. (Figure 6)



- Traumatizing biopsy 3 weeks previously revealing cancer.
- Triple biopsy NEGATIVE GLANDS.

FIGURE 6

Problem: Could the partly disseminated cancer be completely removed by radical mastectomy? Had it, in the three weeks since biopsy, spread to nodes outside the field of radical operation?

Evaluation: Triple biopsy revealed no evidence of cancer in Halsted's nodes and in nodes from the second intercostal space. Bone marrow biopsy and complete x-ray survey were negative.

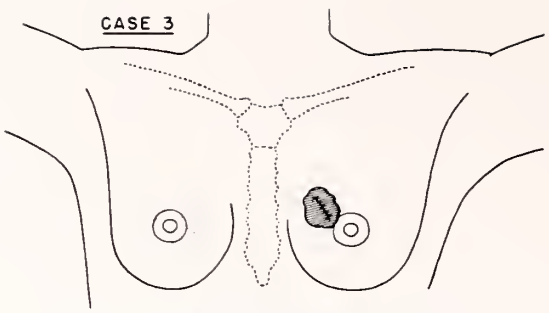
Treatment: Ultra-radical mastectomy done approximately three and one-half weeks after the initial biopsy, removing virtually the parietes overlying the left anterior hemi-thorax and covering the defect with several thick-split skin grafts. Examination of the resected specimen by the pathologist revealed several (6-7) discrete areas dispersed in the left breast, all apparently the same size, age and degree of infiltration, suggesting multi-centric duct cell cancer. Axillary nodes negative.

Course: Patient clinically free of cancer one year after surgery and is well and active one and one-half years from onset of cancer.

Case No. 3—H.B. Age 40

Simple excision elsewhere of cyst of upper inner quadrant, right breast, with malignant duct cell cancer found in wall of cyst, nine months previously. Due to administrative error, follow-up failed. Lump re-appeared in same area and grew slowly six months after surgery. (Figure 7)

Problem: Had advanced metastasis occurred, making radical operation unfeasible?



- Recurrent cancer at site of local excision of cyst one year previously. Abnormal texture, right breast
- Biopsy right breast NEGATIVE.
- Left triple biopsy NEGATIVE GLANDS.

FIGURE 7

Evaluation: Triple biopsy negative. Bone marrow biopsy and x-ray survey negative.

Treatment: Because of induration in right breast, although negative to biopsy, and because of encroachment of initial lesion and previous surgery on medial parasternal tissues, a bilateral mastectomy, removing the right breast by simple mastectomy and doing a radical mastectomy with skin grafting on the left, was carried out. Axilla found negative.

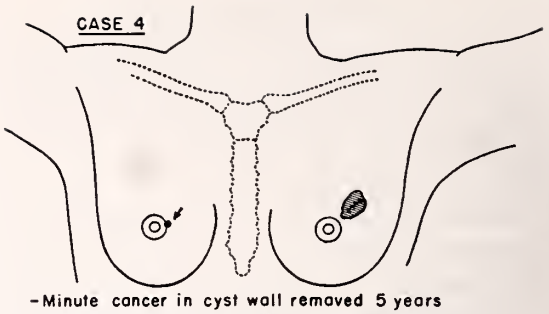
Search of the mastectomy specimen revealed residual cancer at the site of previous operation entirely similar to microscopic appearance of primary growth removed nine months previously.

Course: Patient alive and well two years after surgery. No evidence of residual or recurrent cancer, and alive and well three years after apparent onset of cancer.

Case No. 4—E.K. Age 64

Local excision elsewhere of cyst, upper and outer quadrant, left breast, five years previously. Small focus of cancer found in cyst wall by pathologist. Due to administrative error this was not followed up. Developed local recurrence beneath scar four and one-half years after surgery. Examination revealed also a tiny 1 cm. diameter nodule in right breast at 3 o'clock in the areolar margin, unsuspected by the patient but suspicious of cancer. Axilla and supraclavicular areas on both sides were clinically negative. (Figure 8)

Problem: In the face of untreated, and undoubtedly recurrent cancer of the left breast: (1) Was the nodule in the right breast a metastasis or a second primary cancer? (2) Was the cancer in the left breast still resectable in the face of a five-year history of apparent



- Minute cancer in cyst wall removed 5 years previously. Local recurrence 4-1/2 years later. Small infiltrating duct cell cancer, right breast.
- Double triple-biopsy NEGATIVE GLANDS.

FIGURE 8

failure to metastasize to the axilla or elsewhere, and with a local recurrence developing after inadequate surgery only after four and a half years had elapsed? (3) If the nodule in the right breast was a cancer de novo, could one assume it to be as avirulent as the cancer in the left breast apparently had been? (4) Should a bilateral radical mastectomy be done in this 64 year-old woman with a bad heart, or would bilateral simple mastectomy suffice? (5) If an attempt at cure were feasible, could one logically compromise on something less than bilateral radical mastectomy in this patient for whom the risk of such a procedure was considered too great to be justifiable.

Evaluation: Primary biopsy of suspicious nodule in right breast revealed infiltrating duct cell carcinoma, differing in microscopic appearance from the sections taken from the original tumor in the left breast five years previously which had been obtained for comparison. Bilateral triple biopsy was negative for cancer extension. Bone marrow biopsy and complete x-ray survey were also negative. The microscopic appearance of the tumor now present in the left breast, presumed to be local recurrence, was described by the pathologist as a "Malignant alteration in an extremely large intracystic pseudoglandular papilloma." It was felt, therefore, that the tumor in the left breast represented a late local recurrence of an incompletely excised malignant intracystic papilloma of very low virulence and that it probably had neither infiltrated nor metastasized. The tumor in the right breast, however, was a different type, small, already infiltrating, and about whose characteristics and behavior, we were totally ignorant. It was presumably capable of rapid spread and metastasis. We could not feel any assurance that it had not already reached

the axilla and, therefore, could only be dealt with from a curative standpoint by radical mastectomy. With a bilaterally negative triple biopsy, it was considered suitable for cure by radical mastectomy. As a calculated risk in this far from ideal surgical patient, it was thought that the sluggish tumor of low malignancy in the left breast might be extirpated by thorough, extensive simple mastectomy combined simultaneously with the radical procedure on the right side.

Treatment: A bilateral mastectomy performing a radical mastectomy on the right side for cure of the recent, small, infiltrating cancer was done simultaneously with wide removal of the left breast and pectoral fascia by simple mastectomy. The central defect was covered with split skin grafts taken from the thigh. Both axillas negative.

Course: Patient made an uneventful recovery and is now clinically free of breast cancer three years later. Six months ago, she developed a third primary carcinoma, this time of the bladder wall, which has apparently been completely controlled by local excision and fulguration. She is alive and well eight years after onset of her original left-sided breast cancer and three years after mastectomy.

Case No. 5—C.C. Age 44

Slightly tender, 2.5 cm. lump, present ten days, in upper and outer quadrant, left breast, and painless 1.5 cm. lump present two days, inner and upper quadrant, right breast. (Figure 9)

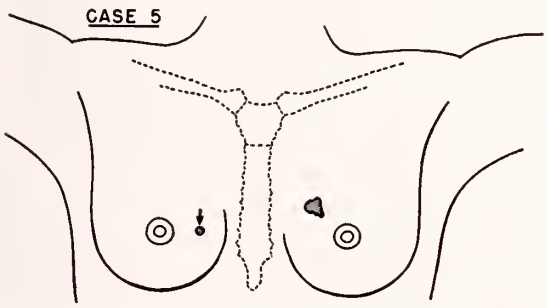


FIGURE 9

Problem: (1) Was mass in right breast a trans-mammary metastasis of primary cancer in left breast? (2) Were there two primary cancers, one in each breast?

Evaluation: A double triple biopsy revealed scirrhous cancer in the right breast, medullary cancer in the left breast, apparently dissimilar in microscopic appearance. The supraclavicular nodes and the internal mammary nodes were negative bilaterally. Bone marrow biopsy and x-ray survey were likewise negative.

Treatment: Bilateral simultaneous radical mastectomy carried out with coverage of the central defect by thick split-skin grafts. Left axilla positive.

Course: Patient alive and well with no evidence of breast cancer two and one-half years after surgery and onset of her cancers. Has just developed early squamous cell cancer of the cervix which is thought to be now controlled by intensive irradiation therapy.

Summary

Radical operations for the cure of breast cancer must be applied against the disease in its early stages. Even in these early stages the operation for cure must be unusually extensive to succeed. Such an extensive operation is mutilating, costly and generally unpopular. More careful selection of patients suitable for such an operation is mandatory and can be achieved by a technique of multiple sampling called "Triple Biopsy," supplemented by routine bone marrow biopsy. Our experiences with triple biopsy, bone marrow biopsy and with the ultra-radical mastectomy of Haagensen are presented.

Bibliography

1. Deaton, W. Ralph, Jr., and Bradshaw, H. H.: Simple or Radical Mastectomy: An Analysis of Cases. Sou. Med. Journal 44:1042-1045, 1951.
2. Wangensteen, O. H.: Super-racial Operation for Breast Cancer in the Patient with Lymphnode Involvement. Proc. of the Second National Cancer Conference, Cincinnati, O. pp. 230-242, March 1952.
3. Urban, J. A.: Radical Mastectomy in Continuity with En-Bloc Resection of the Internal Mammary Lymphnode Chain. A New Procedure for Primary Operable Cancer of the Breast. Cancer 5:992-1008, 1952.
4. Haagensen, C. D.: Symposium on Cancer of Breast: Technique for Radical Mastectomy. Surgery 19:100-131, 1946.
5. Haagensen, C. D., and Stout, A. P.: Carcinoma of the Breast: Criteria of Operability. Ann. Surg. 118:859-870, 1943.
6. Idem. Ann. Surg. 118-1032-1051, 1943.
7. Haagensen, C. D., and Stout, A. P.: Carcinoma of the Breast: Results of Treatment. Ann. Surg. 116:801-815, 1942.
8. Monroe, Clarence W.: Lymphatic Spread of Carcinoma of the Breast. Arch. Surg. 57:479-486, 1948.
9. Andreassen, M., and Dahl-Iversen, E.: Recherches sur les metastases microscopiques des ganglions lwmphatiques sus-claviculaires dans le cancer du sein. J. Internat. Chir. 9:27-40, 1949.
10. Dahl-Iversen, E., and Soerensen, B.: Recherches sur les metastases microscopiques des ganglions lymphatiques parasternaux dans le cancer du sein. J. Internat. Chir. 11:492-509, 1951.
11. Andreassen, M., Dahl-Iversen, E., and Soerensen, B.: Glandular metastases in carcinoma of the breast. Lancet IV, 1:176-178, January 23, 1954.
12. Handley, R. S., and Thackray, A. C.: Invasion of internal mammary lymphnodes in cancer of the breast. British M.J., pp. 61-64, January 9, 1954.
13. Warren, Shields, and Thompkins, Victor: Significance of the Extent of Axillary Metastases in Carcinoma of the Female Breast. S. G. & O. 76:327-330, 1943.
14. McDonald, J. J., Haagensen, C. D., and Stout, A. P.: Metastasis from Mammary Carcinoma to the Supraclavicular and Internal Mammary Lymphnodes. Surgery 34:521-542, 1953.
15. Hyman, George A.: A Comparison of Bone Marrow Aspiration and Skeletal Roentgenograms in the Diagnosis of Metastatis Carcinoma. Cancer 8:576-581, 1955.
16. Daland, E. M.: Untreated Cancer of the Breast. S. G. & O. 44:264-268, 1927.
17. Lazarus-Barlow, W. S., and Leeming, J. H.: The Natural Duration of Cancer. Brit. M.J. 2:266-267, 1924.

CLINICAL OTOSCLEROSIS—FENESTRATION OR STAPES MOBILIZATION*

ARTHUR L. JUERS, M.D.**
Louisville

SURGICAL restoration of serviceable hearing in cases of clinical otosclerosis has become universally accepted. The lesion in clinical otosclerosis is a localized osteodys-

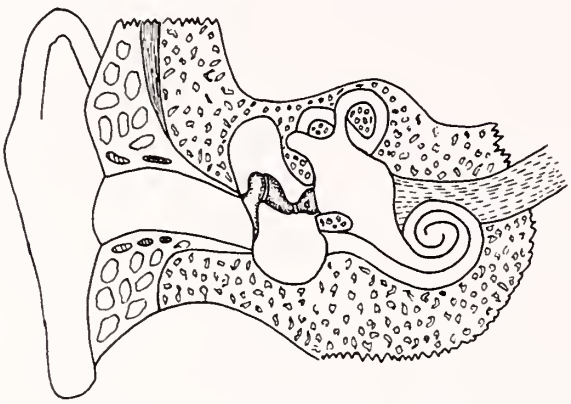


FIGURE 1
Schematic drawing of the ear showing a normal, unimpeded conduction mechanism.

trophy at the anterior edge of the oval window. As the lesion expands, slowly progressive ankylosis of the footplate of the stapes occurs and this produces a conduction deafness (Fig. 2). The lesions are usually bilateral, although

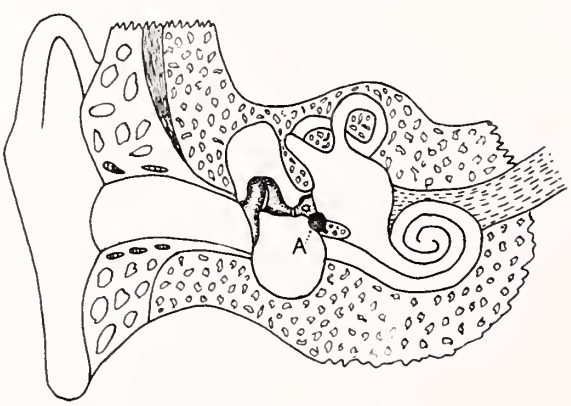


FIGURE 2
Otosclerotic focus at A has produced ankylosis of the stapes in the oval window.

unilateral ankylosis is seen in some instances. There is no medical treatment, either preventive or curative.

When the degree of deafness reaches the handicapping stage, the patient must choose between using a hearing aid or considering surgery. There are at the present time two surgical procedures which will enable the patient to be rehabilitated without using a hearing aid. These are the fenestration operation and the stapes mobilization technic.

Fenestration

The first successful fenestration was performed by Sourdille of France about 25 years ago. His was a multiple stage operation which necessitated months of hospitalization. In this country in 1938 Lempert[1] reported adapting Sourdille's multiple stage postauricular operation to a one-stage endaural procedure. This endaural technic is the one now most commonly used. The basic principle of this operation is to bypass the ankylosed ossicular chain by creating a new channel for sound to enter the inner ear. This is accomplished by making a window (fenestra) in the lateral semicircular canal (Fig. 4). The non-functioning incus and head

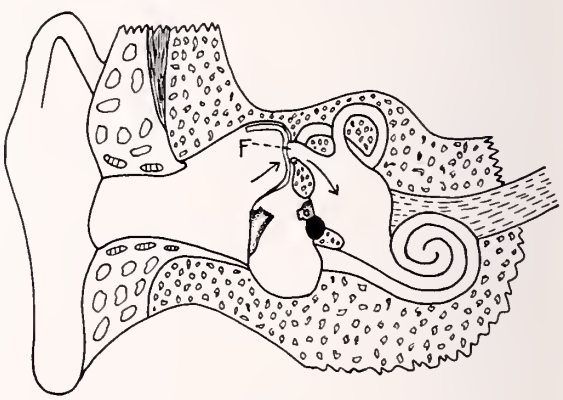


FIGURE 4
In the fenestration operation, the stapes area is bypassed and a new channel for sound to enter the inner ear is created at F in the lateral semicircular canal. The incus and malleus head are removed. The fenestra is covered with skin from the meatal lining. Sound then enters the inner ear through F as indicated by the arrows.

of the malleus are removed in order to provide adequate surgical exposure of the fenestra site. The skin from the external meatus is fashioned into a pedicle skin flap which is placed over the fenestra. In the early genesis of this technic, bony closure of the fenestra with loss of hearing improvement was common. However, with current refinements of technic, bony closure is infrequent.[2] At the present time 80-85%

*Presented before the Kentucky Eye, Ear, Nose and Throat Society, Sept. 19, 1956, during the Annual Meeting.

**Department of Otolaryngology, University of Louisville Medical School.

of ideally suited cases operated on will be able to carry on in social and economic situations without using a hearing aid.

The fenestration operation is a major procedure necessitating about a week of hospitalization. The early postoperative vertigo is the most unpleasant aspect of the operation. The surgery is without shock and in several hundred operations performed by the author, there has been no mortality or incapacitating sequellae.

Stapes Mobilization

Stapes mobilization technic has recently been revived by Rosen[3] and seems to hold promise as another method of restoring serviceable hearing in many cases of clinical otosclerosis. Attempts to mobilize ankylosed stapes were first described by European otologists 75 years ago. The inadequacy of surgical technics and complicating infections resulted in abandonment of the procedure. In 1952 Rosen reported his first successful stapes mobilization. The resurrection of the previously abandoned procedure was initially greeted with skepticism. However, in the past few years it has been accepted by most critical otological surgeons and will from now on undoubtedly be a part of our surgical armamentarium in clinical otosclerosis.

In contrast to the fenestration operation, the mobilization technic is a relatively minor procedure from the patient's standpoint (Fig. 3).

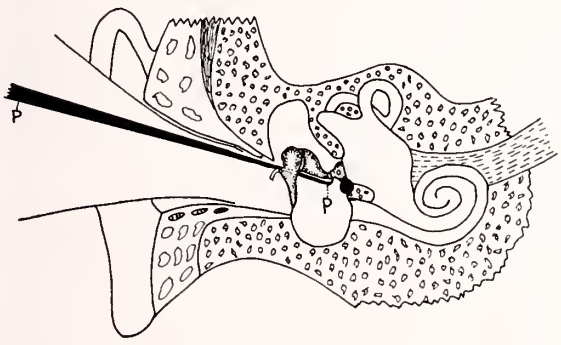


FIGURE 3

A small incision has been made in the meatal skin adjacent to the tympanic membrane to permit the probe P to be introduced into the middle ear. By means of probe manipulation, against the stapes, mobilization of the ankylosed stapes can be accomplished in some instances.

It is carried out under local anesthesia in order that the hearing can be tested during the final stages of the operation. From the surgeon's standpoint, the mobilization operation demands even greater skill and delicacy of technic than fenestration, if optimum results are to be obtained. The patient needs hospitalization for only one day and can return to work after a few days. Occasional nausea and vertigo are experienced a few hours after surgery but have in my experience never persisted beyond 8 or 9 hours after surgery.

Comparison of Results

Unfortunately, the percentage of successful results obtained by mobilization are somewhat less than those obtained by fenestration. At a symposium on mobilization presented at the Triological Society meeting several months ago, the percentage of successful results obtained by several participants varied from 35 to 66%. Rarely is hearing restored to the normal level. In general, if a patient improves to the 30 decibel level or better, the operation is considered satisfactory. Apparently the reason that normal hearing is not obtained more often is that the friction remaining in the fracture line through the otosclerotic focus offers slight resistance to unimpeded vibratory motion of the stapes footplate in the oval window.

In a series of cases in which I have recently carried out the mobilization technic, useful improvement in hearing has been accomplished in approximately 60% of the cases (Fig. 5).

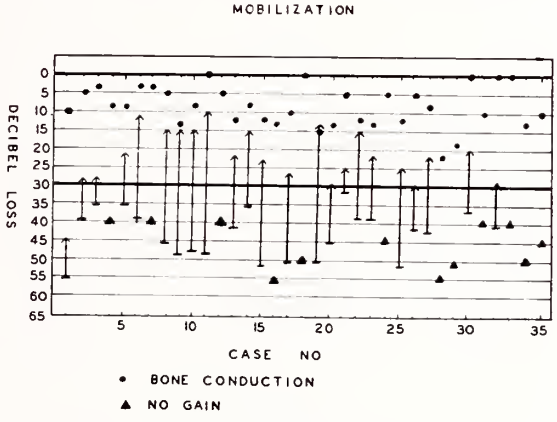


FIGURE 5

Each vertical arrow represents the hearing improvement obtained after stapes mobilization. The short horizontal bar at the lower end of each arrow represents the preoperative level. The hearing level is based on the average decibel loss for the three speech frequencies, 500, 1000 and 2000 as determined by air conduction audiometry. The results obtained in 35 consecutive cases are tabulated. Each solid triangle represents a case with no change in hearing acuity.

The criteria of success established in various reports are somewhat varied. In general, improving the hearing to the 30 decibel level or better is an arbitrary measure of successful re-

habilitation in most instances since the patient is, in general, then able to get along without a hearing aid. There are, of course, exceptions to this inasmuch as some people can carry on as satisfactorily with a 35 decibel loss in their vocational or social spheres as others can with only a 25 decibel loss. The individual's particular need for hearing, his ability to use supplemental lip-reading, etc., influence the capacity to get along in spite of a moderate residual of uncorrected hearing loss.

Tinnitus is relieved in the majority of successful mobilizations. The permanency of results obtained by stapes mobilization surgery must await the test of time. Early reports indicate that perhaps about 10% of successful mobilizations will reankylose during the first few months after surgery. After this period there is apparently a good chance that mobility will be maintained at least as far as one or two-year follow-up is concerned. Longer observations than this are not as yet available in significant numbers. Secondary remobilizations have been accomplished in some instances of refixation.

One explanation of the somewhat surprising tendency of mobility to be maintained in such a high percentage of successful cases is the lack of healing potential in otosclerotic bone. Failure of healing in fractures through areas of otosclerosis were reported by European otologists several decades ago.

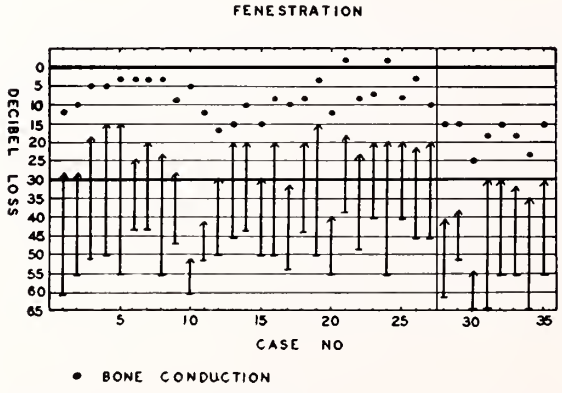


FIGURE 6

Each vertical arrow represents the hearing improvement obtained by fenestration. The first 27 cases were ideally suited to candidates with normal or near normal bone conduction threshold. This is reflected in the greater preoperative loss (lower end of arrow) and in final postoperative levels being somewhat poorer than in the ideal candidate.

Figure 6 represents graphically the results obtained by fenestration in my 35 most recent cases for comparison with a comparable number of mobilizations. In both groups the initial best improvement is tabulated for purposes of comparing results obtained by the two technics. Long range observations indicate that about 10% of successful fenestration cases will lose a significant amount of their initial improvement during the first two years after surgery and will then remain stable.[4] The majority of my early fenestration cases operated on as long as 10 or 11 years ago still maintain a serviceable level of hearing.

In view of the fact that the mobilization technic is a relatively minor procedure, it is, in general, advisable to attempt mobilizing the stapes as the initial surgical means of restoring hearing in deafness due to clinical otosclerosis. This is particularly true for those cases in which there is incomplete ankylosis of the stapes. The chances of successful mobilization are somewhat less in cases of complete ankylosis. Perhaps the chief advantage of the mobilization technic is that relatively little aftercare is needed. The average fenestration cavity requires follow-up care a few times a year for the remainder of the patient's life. In mobilization cases no further care is needed after 3 or 4 postoperative office treatments.

If the mobilization attempt proves unsuccessful, then a fenestration can be performed at a later date. An interval of 3 or 4 months is desirable in order to permit the meatal skin to return to normal.

Summary

1. Surgical restoration of serviceable hearing in clinical otosclerosis is now universally accepted.
2. Stapes mobilization is a minor surgical procedure which is initially successful in slightly more than half of the cases on which it is performed.
3. Fenestration is a major surgical procedure which has a significantly higher percentage of success than stapes mobilization.
4. If a mobilization attempt is not successful, then a fenestration can subsequently be performed.

Bibliography

1. LEMPERT, JULIUS.: Improvement in Hearing in Otosclerosis, Arch of Otolaryngol. 28: 42-97 (July) 1938.
2. SHAMBAUGH, GEORGE, JR. and JUERS, A. L.: Surgical Treatment of Otosclerosis. A Preliminary Report on an Improved Fenestration Technic, Arch. of Otolaryngol. 43: 549-567 (June) 1946.
3. ROSEN, S.: Palpation of Stapes for Fixation. A.M.A. Arch. of Otolaryngol., 56: 610-615, Dec. 1952.
4. JUERS, ARTHUR L. and SHAMBAUGH, GEORGE, JR.: Indications for and End-Results of Fenestration Surgery, Annals of Otol., Rhinol. and Laryngol. 57: 397-412 (June) 1948.

CASE DISCUSSIONS

A CASE OF APPENDICULAR CUTANEOUS FISTULA

Louisville General Hospital

Presentation of case: E. R. CHAPPELL, M.D., Department of Surgery

History

73-year-old white female was admitted to the Louisville General Hospital on September 4, 1956, with a draining sinus right inguinal region.

was first admitted to the hospital in Octo- 1955, because of a tender inflammed mass right inguinal region. From this mass, uring 3 x 3 cm, an estimated two ounces rulent material was removed by incision drainage. Bacteriological studies of this ial were negative for acid-fast bacteria fungi. Physical examination and x-ray s failed to reveal an etiological factor for use of this abscess. The abscess developed a sinus tract which drained periodically December, 1955.

en the patient was next seen on July 17, there was a bloody purulent drainage the right inguinal sinus tract. The drainage ted three weeks and stopped. On August e patient became nauseated and developed ing abdominal pain. The nausea and ab- al pain then ceased, but on August 30, tuant mass was noted in the right inguinal Incision and drainage of the mass pro- 100 cc of thick, yellow, foul-smelling ial. Cultures were negative for acid-fast ia and fungi, but did reveal the presence non-hemolytic Streptococcus and a gram ve rod. The drainage persisted until Sep- r 4, 1956, on which date she was ad- to Louisville General Hospital for explo- of the persistent sinus tract.

ay studies of the gastrointestinal tract igmoidoscopic examination once again to reveal an etiological factor. Lipidol on of the sinus tract revealed pooling of idol in the inguinal area.

Operative Findings

September 17, the sinus tract was care- injected with Methylene blue and an elliptical transverse incision was used to excise the sinus tract, which extended deep to the inguinal ligament up towards the peritoneal cavity. The skin incision was converted into a modified McBurney's incision and the peritoneal cavity entered above the inguinal ligament. The appendix and cecum were readily identified. The appendix was short and stubby with a swollen bulbous tip overlying the proximal end of the previously dissected sinus tract. Appendectomy was performed. Upon opening the appendix Methylene blue was found to be present in the lumen with a small pinpoint perforation in the tip of the appendix which had extended into the sinus tract.

The postoperative course was uneventful.

Discussion

Harold E. Kleinert, M.D.
Department of Surgery

Gould's Medical Dictionary describes a fistula as a narrow tube or canal formed by incomplete closure, as of an abscessed wound, disease process or (congenitally) a part. It usually transmits some fluid, either pus or the secretion of some organ, viscus, or body cavity. Fistulas opening from a viscus to the exterior of the body are named according to the viscus involved.[1] In this particular case the tract extended from the lumen of the bulbous tip of the appendix, deep to the inguinal ligament and drained through the skin of the right inguinal region.

An appendicular cutaneous fistula is uncommon. A review of the recent literature reveals eight cases of appendicular fistulae added to the literature since 1951.[2, 3] All of these cases were internal fistulae extending from the appendix to other internal organs. Prior to 1951

(Continued from Page 1059)

Keeley found three references to appendicoileal fistula.[2]

Mowery and Irvine, in their recent article on appendicular fistulae, make no mention of appendicular cutaneous fistula.[3] However, Bockus states, occasionally an appendicular abscess may burrow to the skin surface, or follow the course of the inguinal or femoral canals, to rupture through the skin and form a sinus.[4]

The complications of appendicitis are infrequently encountered as compared with the preantibiotic days. However, in the "age extreme" patients, either very young or very old, the diagnosis remains a problem, for the classical symptoms and signs are so often lacking.

This 73-year-old female could give no history suggestive of an episode of acute appendicitis. She presented herself with a tender mass in the right inguinal region, which, when incised, drained purulent material. Repeated cultures of the discharge were negative for fungus and tubercle bacilli.

At the time of her last hospital admission, a diagnosis of appendicular cutaneous fistula was strongly entertained. Attempts, however, to demonstrate this fistula by gastrointestinal x-rays and lipidol injection of the sinus tracts were futile. Only at operation when injection with Methylene blue readily outlined the tract and stained the lumen of the appendix was the true etiology of the draining sinus discovered and a diagnosis of appendicular cutaneous fistula made.

Speculation as to probable formation of the fistula is of interest. Inflammation around an appendicular fecalith may have resulted in local tissue reaction, perforation of the appendix, and abscess formation. The abscess then dissected along the femoral canal to manifest itself as an inflammatory inguinal mass. Following the initial incision and drainage of the inguinal abscess a fistula formed and was constantly "fed" by infective secretions from the appendix.

QUESTION: In time would this fistula have closed spontaneously?

H. E. Kleinert, M.D.: Spontaneous closure is highly unlikely for the fistula drained intermittently for almost one year and was well established. The case aptly demonstrates the necessity of discovering the etiology of a sinus or a fistula in order to undertake adequate and appropriate treatment. Excision of the fistulous tract alone, without appendectomy, would undoubtedly result in reformation of an abscess again draining cutaneously to form another appendicular cutaneous fistula.

QUESTION: What other diseases should be considered in a patient with a chronic draining inguinal sinus?

Doctor Kleinert: Tuberculosis or fungus infection such as actinomycosis may produce a chronic draining sinus. A negative Frei test will exclude lymphogranuloma inguinale. Perirectal or anal fistulae may burrow anteriorly and open in the inguinal region. Regional ileitis, a perforated carcinoma of the colon or a perforation of a diverticulum of the colon may form abscesses and finally rupture through to the skin. A Richter's hernia may perforate and drain cutaneously in the inguinal area.

QUESTION: Is x-ray a satisfactory method of demonstrating an entero cutaneous fistula?

Everett L. Pirkey, M.D.: The x-ray diagnosis of intestinal cutaneous fistulae is best made by injecting opaque material under fluoroscopic control directly into the fistula through a small catheter. When the opaque enters the lumen of the portion of the intestine involved one can usually identify the location by the mucosal pattern.

When an opaque substance is given, either by mouth or rectum, there is so much of it scattered through the abdomen that it is impossible to identify the fistula, and the specific loop of gut involved.

QUESTION: If a preoperative diagnosis of intestinal cutaneous fistula is made, what is the surgical approach?

H. E. Kleinert, M.D.: Preoperatively, the intestine should be prepared with a combination of sulfasuxidine and neomycin. Mechanical cleansing of the colon is necessary. At operation the entire fistulous tract should be excised and the intestinal opening closed. Failure to close or resect the intestinal opening will lead to recurrence of the fistula.

References

1. New Gould Medical Dictionary, First Edition, The Blakiston Company, Inc., 1954.
2. Keeley, John L., M.D., Appendicoileal Fistula, Archives of Surgery, Vol. 63, pp. 211-215, 1951.
3. Mowery, William E., M.D., Irvine, Vincent M., M.D., Appendiceal Fistulae, American Surgeon, Vol. 21, No. 8, pp. 794-799, August, 1955.
4. Banks, Roland W., Diseases of the Appendix, Gastroenterology, Vol. 2, Edited by Henry L. Bockus, M.D., W. B. Saunders Publishers, 1946.

The J. A. Hodge Memorial Meeting Of The Kentucky State Medical Association

Columbia Auditorium, Louisville, Kentucky, September 18, 19, 20, 1956
Digest of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Charles A. Vance, M.D., Lexington, Speaker of the House, Presiding

First Session

The first session of the House of Delegates of the Kentucky State Medical Association was called to order by the Speaker, Charles A. Vance, M.D., Monday, September 17, 1956, at 7:22 p.m., at the Columbia Auditorium in Louisville. Charles R. Yancey, M.D., Chairman of the Reference Committee on Credentials, reported that a quorum was present. A motion was made that the minutes of the 1955 meeting be accepted as published in The Journal of KSMA. The motion was seconded and carried.

The Speaker called on the Secretary to read the names of all Kentucky physicians who had died since the 1954 meeting.

Following are the names of these physicians, their location and date of death:

Akin, William E., Jr., Paintsville, August 2, 1956
Barber, Ira Z., Princeton, June 17, 1956
Callihan, G. Darwin, Prestonsburg, October 23, 1955
Chase, Robert L., Glasgow, October 9, 1955
Coffield, Frank C., Salem, July 10, 1956
Collins, B. Lister, Mt. Eden, October 25, 1956
Crow, Thomas A., Manitou, May 18, 1956
Crutchfield, P. H., Georgetown, August 7, 1956
Disbrow, G. Ward, Owensboro, July 22, 1956
Dulaney, Octavus, Louisville, June 17, 1956
Evans, T. A. E., Morehead, March 26, 1956
Fix, Carroll C., Bedford, June 7, 1956
Fitzpatrick, J. W., Louisville, July 25, 1956
Ford, Milton, Warfield, December 24, 1955
Frank, L. Wallace, Louisville, February 10, 1956
Garrett, Nevil M., Brodhead, March 2, 1956
Gordon, Alvah J., Utica, August 16, 1955
Greenwell, J. I., New Haven, May 9, 1956
Hagan, James E., Hazard, October 23, 1955
Haley, Clarence F., Brooksville, October 10, 1955
Hart, L. Scott, Louisa, April 22, 1956
Hughes, Leonidas, Faubush, May 11, 1956
Humphrey, W. O., Louisville, February 23, 1956
Jasper, H. C., Richmond, December 15, 1955
Kavanaugh, Charles N., Lexington, October 29, 1955
Kerns, Ira N., Louisville, November 14, 1955
McAlister, Roy S., Louisville, February 7, 1956
McClendon, John I., Russell Springs, August 3, 1956
McKenney, E. B., Louisville, March 15, 1956
Meadows, Matthew W., Fullerton, June 4, 1956
Messink, W. B., Worthville, July 15, 1956
Neal, Charles A., Nicholasville, October 27, 1955
Northcutt, J. D., Covington, January 21, 1956
Palmer, Martin, Hazard, April 17, 1956
Payne, J. E., West Louisville, January 1, 1956
Phillips, T. L., Kuttawa, May 7, 1956
Poole, William I., Calvert City, December 17, 1955
Pope, Henry C., Richmond, June 22, 1956
Price, J. E., Harrodsburg, August 14, 1956
Pryor, J. W., Lexington, March 17, 1956
Richardson, Ancil A., Williamsburg, March 14, 1956
Richeson, Hugh H., Louisville, July 24, 1956
Robinson, Marion M., Richmond, July 1, 1956
Robinson, Roy F., Madisonville, April 1, 1956
Russell, F. H., Wickliffe, November 7, 1955
Simmons, Simpson J., Greensburg, July 4, 1956
Skaggs, D. Randolph, Ashland, November 3, 1955
Smith, Darwin E., Corbin, April 29, 1956
Smith, Rockwell E., Henderson, April 30, 1956
Smith, Richard S., Versailles, February 6, 1956
Turner, Virgil A., Lewisburg, January 22, 1956
Vicars, T. G., Pineville, March 24, 1956
Wells, George M., Bowling Green, February 25, 1956
Witt, C. B., Louisville, January 9, 1956

A moment of silent prayer was observed in their honor.

The Secretary made the general announcements, which included the addition of two Reference Committees (making the total seven) to facilitate the functions of these committees, authorization by a previous House of Delegates for the Speaker to assign a portion of a specific report to a second Reference Committee if the contents deem such action necessary, and that the last order of business for the first session would be the announcement of the meeting places for the General Nominating Committee and the Councilor Districts Nominating Committees.

Reference Committee appointments were as follows:

Reference Committee No. 1—Reports of Officers and Councilors

E. M. Howard, M.D., Harlan, Chairman
Rankin C. Blount, M.D., Lexington, Vice Chairman
H. E. Martin, M.D., Ashland
A. O. Miller, M.D., Louisville
J. L. Tanner, M.D., Henderson

Reference Committee No. 2—Reports on Medical Care, Medical Education and Related Subjects

Richard G. Elliott, M.D., Lexington, Chairman
Chris Jackson M.D., Danville, Vice Chairman
John D. Handley, M.D., Hodgenville
W. Buford Davis, M.D., Louisville
Marc Reardon, M.D., Covington

Reference Committee No. 3—Reports on Legislation and Public Relations

Charles H. Maguire, M.D., Louisville, Chairman
Carl Fortune, M.D., Lexington, Vice Chairman
Donald L. Graves, M.D., Frenchburg
Ralph D. Lynn, M.D., Elkton
Norman Adair, M.D., Covington

Reference Committee No. 4—Reports on Miscellaneous Business

T. O. Meredith, M.D., Harrodsburg, Chairman
W. E. Becknell, M.D., Manchester, Vice Chairman
F. P. Giannini, M.D., Princeton
Robert S. Dyer, M.D., Louisville
T. R. Davies, M.D., Barbourville

Reference Committee No. 5—Reports on Miscellaneous Business

Roy H. Moore, Jr., M.D., Louisville, Chairman
Frank Duncan, M.D., Monticello, Vice Chairman
Glenn W. Bryant, M.D., Louisville
A. D. Butterworth, M.D., Murray
Charles F. Martin, M.D., Winchester

Reference Committee No. 6—Reports on Miscellaneous Business

Leon Higdon, M.D., Paducah, Chairman
Carl Pigman, M.D., Whitesburg, Vice Chairman
Blaine Lewis, Jr., M.D., Louisville
Douglas Jenkins, M.D., Richmond
W. G. Edds, M.D., Calhoun

Reference Committee No. 7—Reports on Miscellaneous Business

L. F. Beasley, M.D., Franklin, Chairman
Keith P. Smith, M.D., Corbin, Vice Chairman
Carl Cooper, M.D., Bedford
Charles C. Rutledge, M.D., Hazard
J. A. Llewellyn, M.D., Louisville

Credentials Committee

Charles R. Yancey, M.D., Hopkinsville, Chairman
Glenn Marcum, M.D., Irvine
E. A. Barnes, M.D., Albany

Alternate Members to Reference Committees

J. P. Wyles, M.D., Cynthiana
Ward Bushart, M.D., Fulton
J. S. Williams, M.D., Nicholasville
W. P. McKee, M.D., Eminence
Robert Hoffman, M.D., South Fort Mitchell
John Allen, Jr. M.D., Louisville
George Riley, M.D., Erlanger
S. E. Farmer, M.D., Brownsville
David Asher, M.D., Pineville
J. W. Miller, M.D., Greensburg
D. G. Miller, M.D., Morgantown

The following reports of officers were presented at this time and referred by the Speaker to the Reference Committee (s) indicated below:

Report of the President—Reference Committee No. 1, except last paragraph on page 1 and first paragraph on page 2, which were referred to Reference Committee No. 5

Report of the President Elect—Reference Committee No. 1

Report of the Speaker of the House—Reference Committee No. 1

Report and Recommendations of the Council—Reference Committee No. 1 except as follows: last paragraph on page 15 and last three paragraphs on page 16 to Reference Committee No. 3, Supplement "A" to Reference Committee No. 3, Supplement "C" to Reference Committee No. 5, Supplement "D" to Reference Committee No. 5, Resolution (U of K) to Reference Committee No. 3, and Resolution (Code of Ethics) to Reference Committee No. 2.

Hugh P. Adkins, M.D., Louisville, a member of the Committee to Select Award Recipients, presented the committees nominations as follows:

Distinguished Service Award—Joseph T. Molony, M.D., Covington, Outstanding General Practitioner Award—C. T. Coleman, M.D., Frankfort.

Report of Secretary Pro tem—Reference Committee No. 1 except the last paragraph on page 5 entitled "Recommendations," which was referred to Reference Committee No. 5

Report of Editor Pro tem—Reference Committee No. 1 except the last paragraph on page 4, which was referred to Reference Committee No. 5

Report of the Treasurer—Reference Committee No. 1

Report of Delegation to AMA—Reference Committee No. 6

Committee on Arrangements—Reference Committee No. 6

Committee on Scientific Assembly—Reference Committee No. 6

Committee on Public Information and Service—Reference Committee No. 3

Committee on Medical Services—Reference Committee No. 2

Committee to Study The Constitution and Bylaws—Reference Committee No. 5

Medico-Legal Committee—Reference Committee No. 3

Kentucky Committee for Contribution to American Medical Education Foundation—Reference Committee No. 7

Committee on Cerebral Palsy—Reference Committee No. 6

Committee on Corporate Practice of Medicine—Reference Committee No. 3

Diabetes Committee—Reference Committee No. 4

Dietetic Committee—Reference Committee No. 4

Advisory Committee to the Editor—Reference Commitee No. 1

Committee on Emergency Medical Service—Reference Committee No. 6

Committee on Geriatrics and Long-term Illness—Reference Committee No. 7

Committee on Hospitals—Reference Committee No. 2

Insurance Committee—Reference Committee No. 6

Kentucky State Advisory Committee to Selective Service—Reference Commitee No. 6

KSMA Dental Committee—Reference Committee No. 7

KSMA Pharmacy Committee—Reference Committee No. 7

KSMA Physicians Placement Service—Reference Committee No. 2

Legislative Committee—Reference Committee No. 3

McDowell Home Committee—Reference Committee No. 4

Committee on Postgraduate Medical Education—Reference Committee No. 2

Committee to Study Medical Examiner System—Reference Committee No. 3

Medical School Advisory Committee—Reference Committee No. 2

Committee on Nurse Training—Reference Committee No. 2

Professional Relations Committee—Reference Committee No. 2

Committee on Rural Health—Reference Committee No. 7

Committee on School Health—Reference Committee No. 7

Veterans' Committee—Reference Committee No. 3

World Medical Association Committee—Reference Committee No. 5

Committee to Study Committee and Organizational Structures—Reference Committee No. 5

Advisory Committee on Blood Banks—Reference Committee No. 5

Advisory Committee on Cancer—Reference Committee No. 5

Advisory Committee on Crippled Children—Reference Committee No. 5

Advisory Committee on General Practice—Reference Committee No. 5

Advisory Committee on Industrial Medicine and Surgery—Reference Committee No. 4

Advisory Committee on Mental Hygiene and Mental Institutions—Reference Committee No. 4

Advisory Committee on Infant and Maternal Mortality—Reference Committee No. 6

Advisory Committee on Pediatrics—Reference Committe No. 5

Advisory Committee on Physical Therapy—Reference Committee No. 7

Advisory Committee on Public Health—Reference Committee No. 4
Advisory Committee on Tuberculosis—Reference Committee No. 5
Advisory Committee to Blue Cross—Reference Committee No. 4
Advisory Committee to United Mine Works Welfare & Retirement Fund—Reference Committee No. 3
Advisory Committee to Woman's Auxiliary—Reference Committee No. 4
Committee on Scientific Exhibits—Reference Committee No. 6
Committee on Technical Exhibits—Reference Committee No. 7
Report of Woman's Auxiliary—Reference Committee No. 6
Board of Directors of the Kentucky Physicians Mutual, Inc.—Reference Committee No. 5
Rural Kentucky Medical Scholarship Fund—Reference Committee No. 5
Conference of Presidents and Other Officers of State Medical Associations—Reference Committee No. 7
Commission for Improvment of Patient Care—Reference Committee No. 7
Advisory Council to University of Louisville School Student AMA Chapter—Reference Committee No. 7

The following new business was presented and referred by the Speaker to the indicated Reference Committees:

(A) Resolution of the Jefferson County Medical Society concerning mandatory American Association dues—Reference Committee No. 4

(B) Resolution of the Jefferson County Medical Society concerning the reapportionment of Councilor Districts—Reference Committee No. 1

(C) Resolution of the Daviess County Medical Society concerning the Journal of KSMA—Reference Committee No. 1

(D) Resolution of the Perry County Medical Society concerning the article in September, 1956 issue of Reader's Digest regarding the UMWA—Reference Committee No. 1

(E) Resolution of the Fayette County Medical Society concerning the regulation of fees—Reference Committee No. 2

(F) Resolution of the Pulaski County Medical Society concerning the essay contest of the Association of American Physicians and Surgeons—Reference Committee No. 3

(G) Resolution of the Jefferson County Medical Society concerning the Journal of the KSMA—Reference Committee No. 1

(H) Resolution of the Warren County Medical Society concerning the number of delegates per county society—Reference Committee No. 5

(I) Resolution of the Jefferson County Medical Society concerning the Kentucky Exposition Center—Reference Committee No. 3

(J) Resolution of the Harlan County Medical Society concerning the article in the September, 1956 issue of Reader's Digest regarding the UMWA—Reference Committee No. 1

(K) Resolution of the Pike County Medical Society concerning unethical practices—Reference Committee No. 3

At this point the Secretary, at the request of Speaker, designated the meeting places in the auditorium for the General Nominating Committee and the Councilor Districts Nominating Committees. He also announced that the recommendations for the various State offices would be announced the following day, at the beginning of the Second Scientific Session; and that they would again be read at the Wednesday night session of the House, at which time additional nominations might be made from the floor without discussion or comment.

There being no further business a motion was made and seconded that the meeting adjourn at 11:13 P.M. Motion carried.

Second Session

The second session of the House of Delegates of the Kentucky State Medical Association was called to order by the Speaker, Charles A. Vance, M.D., Wednesday, September 19, at 7:21 P.M. in the Columbia Auditorium, Louisville. Charles R. Yancey, M.D., Chairman of the Reference Committee on Credentials, reported that a quorum was present.

J. Vernon Pace, M.D., Chairman of the Council, presented the final reports of the Council, as follows:

The Council passed the following Resolution at its September 19 meeting:

"WHEREAS, the 1956 Annual KSMA Meeting has been enthusiastically received and felt by all to be most worthwhile, and

"WHEREAS, many individuals, organizations and agencies, including Scientific and Technical Exhibitors, newspapers, radio and television stations, state and natonal scientific essayists, hotels and the Columbia Auditorium have contributed to its success, and

"WHEREAS, the members of the faculty of the University of Louisville organized and presented three very valuable and practical Postgraduate Refresher Courses during our annual meeting,

"NOW, THEREFORE, be it resolved that the House of Delegates go on record as expressing its deep appreciation to all who have had a part in the development and implementation of the 1956 KSMA Annual Meeting."

Mr. Speaker, I move the adoption of this report. The motion was seconded and carried.

The Council passed the following resolution at its meeting on September 19:

"WHEREAS, the Kentucky Medical Association has always been concerned with the unnecessary loss of life and bodily injury resulting from all types of accidents, and

"WHEREAS, a State Department of Safety has been created, the purpose of which will be prevention of all types of accidents, and

"WHEREAS, it has been demonstrated that the primary highway system in Kentucky is no longer adequate to safely carry the increased volume of traffic now using the highways, and will become more inadequate each year if an accelerated building program is not initiated, and

"WHEREAS, the elimination of congestion on primary highways and the promotion of safety, through increased construction of primary highways and a vigorous accident prevention program, are matters of particular interest to the medical profession, and

"WHEREAS, the effectiveness of the Kentucky State Medical Association's rural health program depends, in large measure, upon a good secondary highway system.

"NOW, THEREFORE, be it resolved by the House of Delegates of the Kentucky State Medical Association that this Association go on record as endorsing the aims and purpose of the department of safety and favoring the immediate construcion, with all possible speed, of a primary highway system in Kentucky which will safely carry the steadily increasing volume of traffic using such highways; the continued improvement of the secondary highway system upon which the rural population of Kentucky must depend

for medical attention; and the development of a vigorous program designed to materially reduce the appalling number of accidents in the Commonwealth."

Mr. Speaker, I move the adoption of this resolution. The motion was seconded and carried.

The Speaker then recognized Lee Stone, M.D., President of the Illinois State Medical Society.

At this time the reports of the Reference Committees were presented.

REFERENCE COMMITTEE NO. 1

E. M. Howard, M.D., Chairman

Reports of Officers and Councilors

Report of the President

The President gave a resumé of his activities on behalf of KSMA for the past year, among which were visits to all Council Districts and several other medical association meetings. He expressed his gratitude for the support given and confidence shown him by the members of KSMA. The president suggested the KSMA continue to have a medical secretary, that effort be made to increase membership in AMA and secure a third Delegate for Kentucky, and that continued careful consideration be given to the problems created by the establishment of UMWA hospitals in the state.

The Report of the President was approved (except the last paragraph on page 1 and the first paragraph on page 2, which were referred to another Reference Committee).

It was felt that Doctor Gaither should be commended for his fine work and the very active interest he has taken in the Association's affairs during his term of office.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the Report of the President be adopted.

Report of the President Elect

The President Elect summarized his activities for the year and expressed appreciation for the help given him in preparation for his coming responsibilities. With this continued hearty cooperation he is confident the year 1956-57 will be a successful one.

This report was read and unanimously approved.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the Report of the President Elect be adopted.

Report of the Speaker

The Speaker reported that he had appointed the Nominating Committee and Reference Committees in accordance with the Bylaws and expressed hope that the business of the House of Delegates would be conducted without friction and in a fair manner to all concerned.

This report was unanimously approved as read and the Speaker was complimented for his brevity.

Mr. Speaker I move the adoption of this section of the report.

Motion was seconded and carried that the report of the Speaker be adopted.

Report of the Chairman of the Council

The report of the Council was presented by J. Vernon Pace, M.D., Chairman of the Council. The 20-page report was a digest of the four meetings prior to the Annual Meeting.

Report of the Council to the 1956 Session of the House of Delegates

FIRST MEETING. The Council for the 1955-1956 year held its first meeting September 29, 1955, in the Derby Room at the Brown Hotel with Bruce Underwood, M.D., Louisville, serving as temporary chairman. J. Vernon Pace, M.D., Paducah, was chosen chairman and Delmas Clardy, M.D., Hopkinsville, vice-chairman.

Re-organization began with election of two members from the Council to the Executive Committee. (The Bylaws provide that the Executive Committee be made up of the Chairman of the Council, the Vice-chairman, the President, the President-elect, and the Secretary-Editor.) Hugh Mahaffey, M.D., Richmond, and Garnett Sweeney, M.D., Liberty, were elected to serve on the Executive Committee and fill out the membership of seven.

Carlisle Morse, M.D., Louisville, named to the Council by the House of Delegates at its annual meeting the night before to replace President-elect Richard R. Slucher, M.D., was introduced.

The Council proceeded to name committees as provided by the bylaws. It was explained that due to bylaw changes the old Public Relations Committee and the Education Campaign Committee had been combined under the name of the Committee on Public Information and Service, that the Medical-Legal Committee had been abandoned and provision made for a Medico-Legal Administrator. The Council appointed members of the Committee on Public Information and Service, the Committee on Medical Service, The Medico-Legal Administrator, and the Advisory Committee to the Editor. Members of these committees will be found in the committee's directory in the House of Delegates manual. The Council also re-elected for the 1955-1956 year the Lgislative Committee that had served in 1954-1955. It provided that Branham B. Baughman, M.D., Frankfort, and J. Farra VanMeter, M.D., Lexington, would serve as co-chairmen.

(Following the precedent set at the September 11, 1952 meeting of the Council, no individual report of the Executive Committee will be made to the House of Delegates. Under this precedent positive action will be listed in the Report of the Council and, rcommendations noted in actual deliberation of the Council. The Executive Committee held five meetings during the 1955-1956 year.)

Positive actions taken at the November 10 meeting of the Executive Committee held in the office of Dr. Underwood were:

1. President Gant Gaither, M.D., Hopkinsville, reported on the Annual Meeting of the Indiana State Medical Association and the Regional Meeting of the American Medical Association Legislative Committee held at Atlanta, Georgia. He stated that he had spoken at the 11th Councilor District meeting in November at Berea, reported upon plans for the County Society Officers' Conference, and told of development of plans for the Annual Meeting. Following this, he expressed concern over the rapid advancement of large insurance companies in underwriting on an interstate basis of coverage in the field of medical care. He felt that this matter was in the jurisdiction of the Blue Shield plan.

2. Dr. Underwood reported that the KSMA had registered an all-time high in the number of members attending the Annual Meeting—938. He reported that the Field Secretary had been working with the Diabetes Detection Committee and the Legislative Committee, and had carried on two courses for physicians' secretaries. He discussed plans for the Rural Health Conference to be held in January, and the County Society Officers' Conference in March,

as they affected the Headquarters Office.

3. The matter of limited license practices followed by the State Board was discussed in connection with proposed plans to introduce a bill in the 1956 Legislature that would automatically give a limited license man a regular license after having practiced a given number of years. This matter was referred to the Legislative Committee for consideration. Other matters affecting medicine and the health of the people of Kentucky, expected to come up during the Legislature, were discussed.

4. The Committee approved the Kentucky Physicians' Mutual plan to extend its coverage. The matter of distribution of polio vaccine was discussed. The Executive Committee took the position that the immunization program should proceed with full speed and the public be advised that this was the time for immunizations to be given.

5. Wyatt Norvell, M.D., New Castle, appeared before the Committee and explained that the 1957 National Conference on Rural Health would be brought to Louisville on March 7, 8 and 9. He said that the AMA Rural Health Council chairman had specifically asked this Association to send two representatives to the 1956 National Conference at Portland with the view of being better informed on preparing for the Louisville meeting in 1957. The Executive Committee voted to send Dr. Norvell and the Executive Secretary to the 1956 conference. Date of the 1958 Annual Meeting of the Association was set at September 23, 24 and 25. President Gaither discussed the advantages of enacting basic science legislation in this State. The Executive Committee voted to stand behind Dr. Gaither in making a further investigation of this matter.

(This meeting, scheduled to start earlier in the day, did not get underway until mid-afternoon due to conflict with other meetings in which committee members were involved.)

The Executive Committee held its second meeting, a day-long affair, in Louisville, December 14, 1955. Positive actions taken were:

1. President Gather stated that the program for the County Society Officers' Conference had been completed and would present a most worthy and interesting session, and that he had sought to support the counties of Dr. Mahaffey's district in getting them to attain 100% membership.

He indicated that he had asked all Councilors to report on indigent care and basic science legislation at the December 15 meeting. He stated he had appointed a Senior Day Committee to develop the program for April 16 when Elmer Hess, M.D., president of the AMA, would be present. He stated the Committee on Scientific Assembly was preparing the 1956 program and informed the Council he would participate in the Rural Health Conference on January 19.

(No report of the Headquarters Office was given at this meeting because it was not possible for Dr. Underwood to attend. However, the Council held a meeting the next day at which time the Headquarters Office report was made.)

2. The Committee thanked President Gaither for expressing the appreciation of the Association to the Ford Foundation for its generous gifts to Kentucky hospitals and colleges.

3. A resolution submitted by the Jefferson County chapter of the Kentucky Academy of General Practice was read. The resolution stated that the Academy was "opposed to needlessly eliminating commercial distribution of polio vaccine." The Committee concurred with the Academy's views and authorized the Headquarters Office to so inform the Jefferson County Chapter.

4. The report of the Committee on Corporate Practice of Medicine was read, discussed and accepted. This report stated that the Committee was working on the problem.

5. The problem of physicians transferring from one state to another and becoming members after the calendar year gets underway was discussd. It was decided that state dues charged members coming in during the year would be figured on a pro-rata monthly basis.

6. The following request was received from Kentucky Public Health physicians:

"1. That other specialty groups are recognized by the Society and as such have specialty meetings at designated times during the Annual State Meeting.

"2. That other specialty groups, although allied with us through the State Society are primarily interested in treatment, whereas Public Health Physicians are primarily interested in prevention.

"3. Therefore, it is requested that the Executive Committee take cognizance of this and consider the following for necessary action.

"A. Recognize Public Health work as a specialized branch of medicine.

"B. Recognize that specialized needs for lectures and/or training are in prevention rather than treatment, and that it is our double duty to keep abreast with the newest treatments and techniques in all fields.

"With the above in mind, to officially allocate us some time during the meeting, preferably on the one-half day that other specialty groups meet. Also in the future to be allocated as others, some funds when necessary for speakers of note in Public Health. If this is granted, then we may be able to keep abreast through State Medical Meetings with not only the newest diagnostic methods, treatments and techniques of private practitioners, but also keep abreast in our own specialized field.

"Presented in hope that this may provide a better understanding between Private Practitioners and Public Health workers throughout the state, and lead to better health for the citizens of Kentucky."

It was moved and seconded that this request be granted. The motion passed unanimously.

7. The committee reviewed reports of each of the five reference committees adopted by the House of Delegates at the 1955 meeting. Recommendations were assigned to the various KSMA Committees for implementation.

SECOND MEETING. The Council held its second regular meeting of the year on December 15, 1956 in the office of William F. Lamb, M.D., in the State Department of Health building in Louisville.

(See President's report given in the December 14 meeting of the Executive Committee held the day before this meeting. The same report was given at each session.)

Dr. Underwood presented the report of the Headquarters Office. This included a statement that everything was in readiness for the 1956 Rural Health Conference; that the 1955 Diabetes Detection Drive had enjoyed excellent press notices; that plans were well along the way for the 1956 County Society Officers' Conference; and that the Headquarters Office was carrying out the many assignments of the Committee on Scientific Assembly.

Dr. Underwood stated that the Headquarters Office was implementing plans of the Committee on Post-Graduate Medical Education to expand its program, helping with the Senior Day program, carrying out the duties of the KSMA Golf Association.

He told of activity of the Headquarters Office in working with the Editorial Advisory Committee and the Case Discussion Department of the Journal. He said that AMA platters had been placed in twenty-seven of the State's radio stations by the Field Secretary working with the local Medical Society.

The Chairman of the Council stated that five referrals to the Council would be presented at this time, the first four of which dealt with the House of Delegates. They are as follows:

a. The first had to do with KSMA endorsement of

the Minimum Foundation Program. The Council voted to endorse the program as proposed.

b. Following consideration of the 1954-1955 presidential recommendation relating to lay-sponsored health groups, the Council voted to authorize the appointment of a committee to implement the president's recommendation.

c. Consideration was given the Clay County resolution relative to Councilor District representation. The Council voted not to implement the resolution at this time.

d. Consideration was given a resolution dealing with group discrimination by hospitals, passed by the House of Delegates. The Headquarters Office was authorized to send copies of this resolution to interested parties.

e. The fifth recommendation of the Committee pointed out the small amount of time allowed the five reference committees at the annual meeting of the House of Delegates to consider the sixty-odd reports submitted each year to the House. The Executive Committee felt that reference committees should either be given more time or more committees appointed. The Speaker of the House was authorized to appoint seven reference committees for the 1956 meeting instead of five.

The Editor of the Journal of the KSMA, Dr. Underwood, reported on suggested minor changes which looked toward readability and attractiveness of the Journal. With one exception these were adopted. A discussion ensued as to what should be done if and when it became necessary to find a new printer. The Advisory Committee was authorized to proceed with necessary changes without further instruction from the Council.

The Council then went into an Executive Session which lasted until noon.

Following conclusion of the executive session, the Council discussed matters affecting medicine and health likely to be considered at the 1956 Legislature. Dr. Underwood discussed medical licensure problems facing the State Department of Health.

For the Legislative Committee, Dr. Baughman discussed legislative proposals in which the KSMA was interested. These included the proposed change in Kentucky law to make dispensing of narcotics conform with latest Federal regulations; basic science proposals; adjustment of lunacy examination fees; and indigent medical care proposals on which the Association had been working.

Dr. Underwood explained that representatives of the KSMA along with representatives of the Board of Health had been invited to meet with the Governor on December 19. The President, President Elect, Chairman of the Council and C. C. Howard, M.D., of Glasgow, were requested to represent the KSMA at this meeting.

Dr. Pace informed the Council that during the Executive Session Dr. Underwood had resigned as Secretary and General Manager of the Association. It was moved and seconded that Dr. Underwood's resignation be accepted with regret. The motion carried.

THIRD MEETING. The third meeting of the Council was held on January 5, 1956 in the South Room of the Brown Hotel in Louisville.

(Due to lack of time between the December 15 and January 5 meetings, it was not deemed necessary to have the report of the President or Headquarters Office.)

Dr. Underwood, Secretary and General Manager, who had resigned at a previous meeting, was asked to leave the room temporarily. During his absence the Council voted to have a testimonial dinner for him Thursday evening, January 19, at the Kentucky Hotel and authorized the appointment of a committee to purchase a testimonial gift. Following this action, he was asked to return to the room.

The President reported that the special committee to meet with the Governor had a very pleasant and satisfactory meeting with the State's Chief Executive.

The matter of whether or not the KSMA and the State Board of Health should continue to have the same secretary was discussed. The following motion was made: "Moved that the Council vote today and make it a part of its report to the House of Delegates that the Secretary and General Manager of the Kentucky State Medical Association and Commissioner of Health not be the same person." The motion passed. The Council then elected Woodford B. Troutman, M.D., as Secretary-Editor pro tem to serve until the 1956 meeting of the House.

The Council heard a request that the KSMA consider renting office space in the new Louisville Medical Building. It was voted to receive this request as information.

Dr. Underwood discussed what he described as important issues facing the State Department of Health.

The Council named Dr. Slucher, Dr. Troutman and Dr. Baker to represent the KSMA at the meeting of the Council on Allied Medical Services.

Vincent Pierce, M.D., Covington, President of the Kentucky Blue Shield, discussed a program for providing medical care for families of men in the armed forces. The Council voted to receive this information, but took no action.

The Council was informed that Mr. and Mrs. J. G. Denhardt, of Bowling Green, who had published the Journal of KSMA for the past fifty years, were resigning with publication of the April issue. Note was taken of the long and faithful service of the Denhardts. The Council voted the Denhardts be given its sincere thanks and their resignation accepted.

The following are positive actions taken by the January 26 meeting of the Executive Committee, held at the Brown Hotel in Louisville:

1. Dr. Troutman, Secretary-Editor Pro tem, was introduced as the new member of the Executive Committee.

2. The Executive Committee reviewed the indigent care study conducted by the Association and the proposal looking toward enactment of legislation approved by the Council and the 1955 session of the House of Delegates.

3. Due to developments beyond the control of members of the Association and not as a result of any action or failure to act on the part of any member of the Association, the Committee voted to disband the present KSMA Legislative Committee, and at the same time express to the Legislative Committee the profound thanks of the Association for its splendid and efficient service in the past.

After more discussion and careful consideration, it was felt that a smaller committee would perhaps work more efficiently and it was decided to elect Thomas P. Leonard, M.D., Frankfort, as Chairman of the new committee to serve with O. L. Higdon, M.D., Paducah, Alec Spencer, M.D., West Liberty, Norman Adair, M.D., Covington, and William J. Keller, M.D., Louisville (later W. F. Carmichael, M.D., Maysville, was appointed.)

4. Gaithel Simpson, M.D., Chairman of the Committee on Medical Service that had conducted the survey on Indigent Care, was asked to appear before the Committee. Dr. Simpson was authorized to proceed with preparation of a bill to be introduced in the Legislature that would implement the indigent care proposal as passed by the House of Delegates.

5. The matter of KSMA support of safety legislation, involving an expanded program of safety education and practices, was referred to the KSMA Legislative Committee for action.

6. The Committee authorized the Legislative Committee to do all within its power to defeat the bill introduced into the Legislature giving a man who held a limited license for ten consecutive years a regular license.

7. On the National front, the proposal made by HR 7225 to lower the disability benefits to age 50

were discussed. The Committee was told that the AMA had requested the KSMA to send a member to Washington to testify when HR 7225 was considered by the Senate Finance Committee. O. L. Higdon, M.D., Paducah, was elected to represent the Association. The Executive Committee, following receipt of the request from the AMA, voted to authorize a social security poll, and it was decided to conduct this poll in the February issue of the Secretary's letter.

8. It was reported that 161 had attended the testimonial dinner for Bruce Underwood, M.D., sponsored by the Association.

9. The Committee voted to authorize the Legislative Committee to draw an appropriate bill to implement the resolution passed by the House of Delegates, which would adjust fees for lunacy examinations.

Following are positive actions of the Executive Committee meeting in Louisville on May 17, 1956.

1. The President reported he had spoken at the testimonial dinner for Bruce Underwood, M.D., attended a number of the Councilor District meetings, presided at the morning session of the County Society Officers' Conference, spoken at the annual KSMA Senior Day meeting, and attended the Charleston Conference to Study Medical Care Problems in the Soft Coal Mining Area. Also that he had arranged for Association representation at other meetings when it would not be possible for him to attend.

2. In the Headquarters report, Dr. Troutman explained that this office working under special committee had promoted the Bruce Underwood testimonial dinner, that working under the Committee on Rural Health had carried the heavy end of the annual Rural Health Conference for 1957.

He said that the Advisory Committee to the Editor had held a number of meetings and selected a new printer to replace the Denhardts. Also that the Field Secretary had spent most of his time in Frankfort during the Legislature and that the Headquarters Office had co-operated with the Legislative Committee. He reported the County Society Officers' Conference held March 29 was regarded as a success; that the Field Secretary was conducting six public relations courses for physicians' secretaries; that the Headquarters Office had promoted seven Councilor District meetings; and was helping the Committee on the Post Graduate Medical Education program.

He said the Senior Day Program, developed under a special committee, with actions implemented by the Headquarters Office, was regarded as a success and reported the Physicians' Placement Service was expanding its services. A letter from the Chairman of the Committee, Ralph D. Lynn, M.D., Elkton, was read requesting that the Field Secretary be made Field Secretary to the Placement Service. This was voted.

Association membership for the year to date was reported as 1819 members, a new high for this period. The Headquarters Office was actively co-operating with the Committee on Scientific Assembly in developing the 1956 Annual Meeting program and the Association's attorney, E. Gaines Davis, had attended a conference for State Medical Association and County Medical Association attorneys in Chicago sponsored by the AMA. It was indicated that the Legislative Committee and the Women's Auxiliary had been active in their attempts to defeat the disability amendment in HR 7225, and that five physicians elected by the Committee on Public Information and Service would represent the Association at the annual meeting of the Federation of Womens' Clubs on June 5 to present a panel entitled "The Doctor's Role in Our Free Way of Life."

3. The budget for the 1956-1957 year as proposed by the Budget Committee was explained by Dr. Clardy in the absence of the Chairman of the Committee. The Committee accepted the budget with appreciation and recommended its adoption by the Council.

4. The Committee was informed that the term of T. V. Gudex, M.D., on the Hospital Licensure Council, would expire in 1956 and voted to recommend to the Governor that Dr. Gudex be re-appointed.

5. A letter from David M. Cox, M.D., Louisville, stating that he could not serve as an Alternate Delegate to the AMA for Clark Bailey, M.D., until December 30, 1956, was read. Robertson O. Joplin, M.D., Louisville, was elected to take Dr. Cox's place.

6. Dates for the 1957 County Society Officers' Conference were voted for April 4, 1957.

7. The Executive Committee refused the request of an insurance company for a list of new members of KSMA.

8. The date of the 1959 Annual Meeting of the Association was set for September 22, 23 and 24.

9. Correspondence was read by the Secretary Pro tem from Physicians in Eastern Kentucky relating to acceptance of certain doctors as members of the County Society and State Association, and of possible conflict of county society bylaws relating to membership with KSMA bylaws. It was voted to invite to the next meeting of the Council representatives from medical societies in all counties in which the Memorial Hospital Association—an agency of the UMWA is located, to discuss membership problems.

10. The Executive Committee was told that the KSMA Veterans' Affairs Committee had recommended renewal of the contract between the KSMA and the Veterans Administration to provide hometown medical care for beneficiaries of that program. The Executive Committee unanimously accepted the recommendation of the Veterans Committee.

11. Correspondence from the Bullitt County Medical Society requesting reactivation of its charter was read. The Committee received this request favorably and moved that it be sent to the House of Delegates for action.

12. A request of the Chairman of the State Tuberculosis Commission, C. C. Howard, M.D., Glasgow, that the Headquarters Office co-operate in publicizing two seminars each year planned for each of the six sanitariums, was read. The Committee voted to approve Dr. Howard's request.

13. A recommendation was heard from the Committee on Rural Health that the Association work with 4H officials in making available health education information and movies to 4H Club camps throughout the State. This recommendation was approved.

14. The Public Information and Service Committee's recommendation that Senior Day at the University of Louisville School of Medicine become an annual affair and that the President of the Association be authorized to appoint a committee to develop the program was accepted.

15. William H. Cartmell, M.D., Maysville, was elected to fill a vacancy on the KSMA Legislative Committee.

FOURTH MEETING. The fourth regular meeting of the Council was held in the Auditorium of the State Department of Health, Thursday, June 21.

The President reported that minutes of the May 17 meeting of the Executive Committee, recently mailed to members of the Council, had given a detailed report of his activities for the first half of 1956. He stated his plans to speak at a joint meeting of the 12th and 15th Councilor Districts at Cumberland Falls on June 28, and discussed briefly his impressions of the annual meeting of the AMA in Chicago held on June 14. He told of his continued activity in behalf of the defeat of the disability clause in HR 7225.

Dr. Troutman's Headquarters Office report was brief. He stated that the KSMA Legislative Committee had been highly complimented by the AMA Washington office in its effort to defeat HR 7225, that the panel presented by the KSMA at the Kentucky Federation of Woman's Clubs meeting had been successful, and that the Denhardts had thanked The Journal

for the article in the May issue on their services to the Association.

He reported the death of a former KSMA Councilor, J. R. Greenwell, M.D., New Haven, who had been the AMA's outstanding General Practitioner in 1953. He said flowers were sent in behalf of the Association. He pointed out that many favorable comments had been received on the new KSMA Journal; that G. Y. Graves, M.D., had been inaugurated as President of the Conference of Presidents and Other State Medical Association Officers at its 1956 meeting in Chicago just prior to the AMA meeting; and that preparations were going ahead for the 1956 KSMA Annual Meeting. He stated that with the resignation of Raymond Dixon as Executive Secretary of the Rural Kentucky Medical Scholarship Fund, the KSMA Executive Secretary had been elected to fill Mr. Dixon's place and that all activities of the Fund would now be conducted at the Headquarters Office. In addition, that the Field Secretary of the KSMA had been elected as Field Secretary of the Scholarship Fund.

At this point, representatives of county medical societies from Eastern Kentucky, in which UMWA hospitals are located, were recognized and called upon to discuss problems growing out of the operations of these hospitals. Before these men spoke, Dr. Troutman read correspondence relating to this subject received at the Headquarters Office or by officials of the Association.

The morning-long discussion heard representatives from Pike, Bell, and Perry counties. In addition, Carl Fortune, M.D., Chairman of the KSMA Advisory Committee to the UMWA, was called upon to give his views. Guests were invited to eat lunch with the Council.

The first action of the Council after lunch was as follows:

"Doctor Van Meter moved that the Council express its disapproval regarding certain unethical practices approved by those in authority in the new UMWA hospitals in Kentucky; namely, (1) The making of rounds by the clinical director or other staff members on all cases in a hospital, regardless of the physician in charge; (2) The acceptance of non-referral cases in out-patient departments; (3) The acceptance of non-UMWA patients by physicians who are on salary and who maintain office in or out of their respective hospitals; and that these matters be referred to the KSMA Advisory Committee to the UMWA Welfare & Retirement Fund for study and report to the next regular session of the House of Delegates. Doctor Johnson seconded and the motion carried."

The Council agreed to defer action until its next meeting on other problems brought up in the morning discussion.

John D. Handley, M.D., Chairman of the School Health Committee, from Hodgenville, was introduced for the purpose of presenting recommendations from his committee.

Dr. Handley pointed out that school health programs at the local level are important for the health of the child himself, and that the future of medical practice in general may well be influenced by policies in this field. Due to the fact that the "Minimum Foundation Program" includes provisions for expansion of school-sponsored medical services, the Committee felt the opportune time for direction of such programs by the medical and dental professions had arrived.

The Committee felt that community problems could be solved at the local level and no immediate steps should be taken to form a state school health council. It recommended, however, that representatives of other state groups interested in school health be consulted regarding formation of county school health committees. It further recommended that an educational program be directed at the profession regarding the school health problem, and that the Committee undertake encouragement of county medical societies to form school health committees at the local level. The Council approved the recommendations and thanked Dr. Handley and his Committee for their efforts.

The 1956-1957 budget and recommendations, as proposed by the Budget Committee and approved by the Executive Committee were presented by the Chairman of the Budget Committee, Dr. Toomey. These recommendations were unanimously accepted.

The Legislative Committee at its March 29 meeting made two requests of the Council. The first, had four parts, asked the Council for instructions on the following points likely to be brought up at the 1958 session of the Kentucky General Assembly: (1) basic science law, (2) an indigent hospital care program, (3) an amendment to the Optometry Act similar to that defeated in 1954 and 1956, and (4) an amendment to the Hospital Licensure Act to include nursing homes and give them representation on the administrative board. After the reading of the first part of the recommendation, the Council authorized the Association's attorney to study the basic science law and report his recommendations at a later meeting. Action on the other three items was deferred.

The second part of the Legislative request was suggested that an ophthalmologist be named to the KSMA Legislative Committee. The Council authorized the Executive Committee to make this appointment.

Dr. Bailey discussed important subjects on which the House of Delegates of the AMA took action at its 1956 annual meeting in Chicago. These included hospital accreditation, evaluation of graduates of foreign medical schools, private practice by medical school faculty members, federal aid to medical education and premature publicity on new drugs. Vincent Pierce, M.D., Covington, the other Delegate to the AMA, commented briefly on the meeting. At this point the Council went into executive session which lasted forty-six minutes.

It was reported that facilities at the Phoenix Hotel in Lexington were not available for the County Society Officers Conference on March 29, 1957. It was decided to hold the meeting on April 4, 1957. The Council then authorized the purchase of an advertisement in the Kentucky State Fair and Exposition Center special issue of the Courier-Journal, to be published on September 2, 1956. Following this, the meeting adjourned.

(The report of the Council is a summary of actions of the Executive Committee and the Council during the past year. Any delegate or member wishing to read the full minutes of any of the meetings of the Executive Committee or Council is welcome to do so at the Headquarters Office of the Association.

Respectfully submitted,
J. Vernon Pace, M.D.
Chairman of the Council

This report was discussed at some length and it was noted that there had been four meetings of the Council and five meetings of the Executive Committee. The positive actions of the Council and the Executive Committee were noted and approved (except the portions relative to the UMWA problems, which were referred to another Reference Committee).

APPROVED K.S.M.A. BUDGET FOR FISCAL YEAR
July 1, 1956 — June 30, 1957
ESTIMATED ASSETS AS OF JULY 1, 1956

GENERAL OPERATING and JOURNAL ACCOUNTS			
Current Assets:			
CASH IN BANKS:			
Checking Account	$ 2,500.00		
Savings Accounts	45,000.00		
Total Cash in Banks	$47,500.00		
ACCOUNTS RECEIVABLE—ADVERTISING	1,850.00		
ADVANCES for EMPLOYEES' PENSION TRUST PREMIUMS	1,200.00		
Total Estimated Current Assets		$50,550.00	
Fixed Assets:			
Office Equipment—Depreciated Value	$ 4,725.00		
Total Fixed Assets		4,725.00	
Total Estimated Assets—GENERAL OPERATING and JOURNAL ACCOUNTS			$55,275.00
RESERVE FUND ACCOUNT			
INVESTMENTS:			
U. S. Government Bonds—At Cost		$41,006.63	
Louisville Title Mortgage Co. Common Stock—At Cost		755.52	
Cash		1,000.00	
Total Investments—RESERVE FUND ACCOUNT			42,762.15
MCDOWELL FUND ACCOUNT			
Fixed Assets:			
McDowell House—At Appraised Value		$25,000.00	
McDowell Home — Furnishings — Appraised Value Estimated		23,031.00	
Total Fixed Assets—McDOWELL FUND ACCOUNT			48,031.00
GRAND TOTAL of ALL ESTIMATED ASSETS as of JULY 1, 1956			$146,068.15

ESTIMATED INCOME AND EXPENSES, JULY 1, 1956 — JUNE 30, 1957

	Estimated Income	Estimated Expenses
GENERAL OPERATING ACCOUNT		
Income	$69,375.00	
Expenses:		
Current Fund Account		$56,942.50
Officers, Councilors, and Miscellaneous Committees Expense Account		1,200.00
Medico-Legal Committee Expense Account		350.00
Promotional Expense Account		2,000.00
Diabetic Detection Program Account		200.00
Postgraduate Medical Education Program Account		1,000.00
Annual County Society Officers' Conference Account		500.00
Rural Health Committee Account		300.00
Woman's Auxiliary Account		500.00
Physicians' Placement Committee Expense Account		200.00
Total Estimated Income and Expenses—GENERAL OPERATING ACCOUNT	$69,375.00	$63,192.50
JOURNAL ACCOUNT	22,100.00	25,000.00
ANNUAL MEETING ACCOUNT	10,360.00	10,660.00
McDOWELL FUND ACCOUNT	3,000.00	2,600.00
TOTAL BUDGETED INCOME—All Accounts	$104,835.00	
TOTAL BUDGETED EXPENSES—All Accounts	101,452.50	
Gain	$ 3,382.50	

It was felt that the Chairman of the Council should be relieved of reading the full and detailed report of the Council to the House of Delegates; that in the future the principal actions of the Council be published in the issue of the Journal of KSMA following the Annual Meeting; and that the report read to the House of Delegates be a brief resumé of the highlights of the preceding year. The committee felt that Doctor Pace, Chairman of the Council, and the other Councilors should be congratulated on their efficient work during the year.

Mr. Speaker I move the adoption of this section of the report.

Motion was seconded and a thorough discussion followed.

A motion was made to include the following amendment in this section of the report:

That whenever Executive Sessions are mentioned in the minutes, it be clarified that such sessions deal with personality differences and that no actions be taken that effect the policies of the Association.

The motion was seconded and the amendment carried.

Further discussion revealed that it was the intention of Reference Committee No. 1 to recommend that the highlights of the Council meetings be published in the issue of The Journal following each meeting and not in the issue following the Annual Meeting only, as the report implied. A motion was made, seconded and carried that the Secretary be instructed to make this correction.

This portion of the report, as amended, passed.

Report of the Secretary Pro tem

The Secretary Pro tem, who took office the first of February, 1956, reported on the activities of the Headquarters Office for the past year. He mentioned there is scarcely an activity of the Association in which the Headquarters Office does not participate in one way or another. Among these are: promotion of the Rural Health Conference, County Society Officers' Conference, Annual Senior Day Program; the preparation and mailing of the Secretary's Letter and "News Capsules"; the preparation for the Annual Meeting, which means the duplicating of and assembling of reports of more than sixty committees; and expanded activities of the Physicians Placement Service and Rural Kentucky Medical Scholarship Fund. He expressed the appreciation of the Headquarters Office to the President, Chairman of the Council, other officers and committee members, and the Association's attorney, Mr. E. Gaines Davis.

The Secretary Pro tem recommended that the present policy of the Secretary also serving as Editor be abolished and that the positions be separated.

The committee felt that Doctor Woodford B. Troutman should be highly complimented for the fine job he has done as Secretary Pro tem since he assumed this office early in 1956. The committee is cognizant of his numerous activities on behalf of KSMA.

This report was unanimously approved (except the recommendation, which had been referred to another Reference Committee).

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the Report of the Secretary Pro tem be adopted.

Report of the Editor Pro Tem

The Editor Pro tem pointed out two important changes in the Journal; namely, the change in printers and the revamping of the format. The Journal has enjoyed a good year and has received many compliments on the new style and only a few criticisms. The Editor Pro tem expressed appreciation for the diligent services of the Advisory Committee to the Editor, the four scientific editors, the Board of Consultants, and the advertisers. He recommended the proposed separation of the Secretary-Editor.

The Report of the Editor Pro tem was discussed and unanimously approved, except the recommendation which had been referred to another Reference Committee. Again, Doctor Troutman is to be congratulated on his splendid work.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the Report of the Editor Pro tem be accepted.

Report of the Treasurer

The Report of the Treasurer contained the recent audit of the Association's financial situation with statement of the income and expenses for the fiscal year ended June 30, 1956.

The Treasurer's report was carefully studied and unanimously approved.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the Report of the Treasurer be accepted.

Report of the Advisory Committee to the Editor

This report was concerned chiefly with activities following the resignation of the Times-Journal Publishing Company. Upon authorization of the Council the Committee made a thorough study of the status of the Journal and sought advice from every available source. Many helpful suggestions were received, and the new contract was awarded to Gibbs-Inman Co. While much progress has been made, the committee is ever striving to improve the Journal's educational value and reader interest.

This report was discussed and unanimously approved. It was felt that the Advisory Committee to the Editor should be congratulated on the excellent work it has done in the improvement of the appearance of the Journal of KSMA and also in its content.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the Report of the Advisory Committee to the Editor be approved.

Resolution B—Reapportionment of Councilor Districts

"WHEREAS, at present the Kentucky State Medical Association is divided into 15 districts with one councilor elected to represent all the doctors within his district, and

"WHEREAS, the Council is the executive body of the House of Delegates between meetings of the House with full authority to administer the activities and functions of the Secretary and Treasurer of the Association, and

"WHEREAS, the Council has the right and duty to communicate the views of the medical profession in Kentucky in regard to matters of health, medical care and other important items as from time to time may be brought to the attention of the public and the lay press, and

"WHEREAS, in view of the above duties and authority it is necessary that the Council be a truly representative body reflecting equally the views of all doctors within the state, and

"WHEREAS, in the present 15-district apportionment we note that it is possible for a Councilor who represents 60 doctors to truly reflect their views it is nearly impossible for a Councilor representing over 550 doctors to represent all the thinking and views of so large a group. Also it is nearly impossible for one man to discharge his responsibilities as outlined in the bylaws when he is expected to serve as Councilor, censor, and representative for so large a group, and

"WHEREAS, it is of utmost importance that the interest of each county society member be maintained and cultivated in order that the state association may prosper and grow yet it is impossible for the members of a very large district to make the frequent contacts with their Councilor that are desirable, and

"WHEREAS, the method of selecting Councilors with consideration to the doctor population is truly representative and a method that is now in practice by such states as Oregon, Wisconsin, Illinois and others. Many states are now in the process of changing their bylaws to permit this method of selecting Councilors, therefore be it

"RESOLVED, that for reasons as shown above and in the interest of a stronger, more representative, and effective Council the 15 Councilor Districts remain the same but that the Councilors be chosen on the basis of doctor population, and

"RESOLVED, that section 6, chapter V of the bylaws be changed to read as follows:

'The delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating a Councilor or Councilors for the Councilor District concerned. This committee shall hold a meeting open to all active members of the Councilor District concerned who are in attendance at the meeting for the purpose of discussing the nomination for the Councilor or Councilors to serve the District. Where a Councilor District has more than 200 physicians, registered as active members of the state association on or before December 31 the year preceding the annual meeting, that district committee shall nominate for office one additional Councilor for each 200 members or fraction thereof for election. Additional nominations may be made from the floor by any member of the House of Delegates when the Nominating Committee makes its report to the House of Delegates.'

"Also that section 14, chapter IV be amended to insert after the last sentence the following:

'Each Councilor District will be represented in the Council by a Councilor for each 200 active members or fraction thereof.' "

This resolution, submitted by the Jefferson County Medical Society, was discussed at length and numerous witnesses appeared before this committee. It was decided to present this resolution to the House of Delegates without comment.

Mr. Speaker, I move this resolution be submitted to the House of Delegates for action.

The motion was seconded and carried that Resolution B be submitted to the House of Delegates for action.

After considerable discussion, the Speaker ruled, upon advice of the parliamentarian, this resolution could not be adopted by a change in the bylaws, as requested, but would have to be adopted through a change in the constitution; and, consequently, was out of order at this time.

It was moved, seconded and carried that Resolution B be tabled.

Resolution C—Journal of KSMA

"WHEREAS, the official publication of the Association is the Journal of the Kentucky State Medical Association and is basically a scientific publication and is designed to provide the members of the Association with the most recent developments in medicine,

"WHEREAS, the loyal and faithful friends of the Association, the J. D. Denhardts of Bowling Green, saw fit to withdraw as publishers of the Journal after 50 years of excellent service and it became necessary to obtain new printers,

"WHEREAS, the Council of the KSMA delegated to the Advisory Committee to the Editor, under the able chairmanship of Dr. Guy Aud, the duty of finding new printers for our Journal,

"WHEREAS, the Council, following the resignation of former editor Bruce Underwood, elected Dr. Woodford B. Troutman acting editor of the Journal,

"WHEREAS, Dr. Aud and his committee, working with Dr. Troutman and Mr. Sanford, executive secretary, expended many long hours, attended numbers of meetings, held numerous consultations in developing and presenting our new Journal which has been greatly improved and which enhances its effectiveness, usefulness and attractiveness to the members of our Association,

"WHEREAS, our new Journal has received high and genuine praise from the membership of our Association, from the State Journal Advertising Bureau Board of Directors at the AMA in June, from editors of other state journals, and from our respected and appreciated advertisers, from members of our allied professions and from lay people,

"RESOLVED, that this House of Delegates express its deep appreciation to Dr. Aud and his committee, Dr. Troutman, and Mr. Sanford for the splendid contribution they have made to our Association,

"RESOLVED, that this House take this opportunity to express its appreciation to the four scientific editors, Doctors Jack Chumley, Joseph C. Bell, Sam A. Overstreet, and Walter Coe, who work quietly from month to month to provide the readers of the Journal with high quality and constantly improving scientific material."

This resolution, submitted by the Daviess County Medical Society, was approved by this committee.

Mr. Speaker I move the adoption of this section of the report.

The motion was seconded and carried that Resolution C be adopted.

Resolution D—Reader's Digest Article on UMWA, September 1956 issue

"The following resolution was passed by the Perry County Medical Society at its regular monthly meeting, September 10, 1956.

"We feel that the article appearing in Reader's Digest for September 1956 by Ira Wolfert entitled "The Miners' Fund—A Tribute to Good Management," gives a completely false and misleading impression of the medical care in Eastern Kentucky before opening of the UMWA hospitals.

"We feel that this article was written either without proper background information or with the actual intent to degrade medical care practiced here so that by comparison the UMWA Hospital program would be more impressive. Under either circumstance we feel there is no excuse for the impression conveyed by the article and request the House of Delegates of the Kentucky State Medical Association to condemn the article and request a retraction."

This resolution, submitted by the Perry County Medical Society, was discussed and unanimously approved.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that Resolution C be adopted.

Resolution G—The Journal of the Kentucky State Medical Association

"WHEREAS, the Journal of the Kentucky State Medical Association serves the physicians in Kentucky as an important means of education, information and organizational cordination, and

"WHEREAS, there are those who give continuously and unstintingly of their time and talents to further improve the general appearance and effectiveness of this Journal, and

"WHEREAS, we have noted with special interest the very worthwhile changes in format, cover, material and advertising that have been accomplished since the April 1956 issue which have resulted in a much more attractive, readable and interesting publication, therefore,

"BE IT RESOLVED, that the House of Delegates of the Kentucky State Medical Association express its compliments and gratitude to the Editor, Managing Editor, Scientific Editor, Case Discussions Editor, Medical Editorial Editor, Book Review Editor, and Organization Editor for their individual and collective efforts toward this Journal that we may point to with pride."

This resolution, submitted by the Jefferson County Medical Society, was unanimously approved.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that Resolution G be adopted.

Resolution J—Reader's Digest article on Miners' Fund

"Ira Wolfert, a reporter for Reader's Digest, wrote the above article ("The Miners Fund—A Tribute to Good Management") in the September issue of the Reader's Digest distorting facts, giving the impression in the article that the people in the Kentucky—West Virginia mountainous areas were dying for lack of medical care. That the doctors were practicing medieval type of medicine up until a few months ago. That the good citizenry of this area were substandard.

"WHEREAS, we as members of the medical profession disapprove of such methods of writing, and especially the smearing of citizens who are making every effort to be good citizens.

"Be it therefore, resolved that the members of the Harlan County Medical Society express themselves as disapproving such a misleading article, and therefore express our keen disappointment in such a poor exhibition of journalism by the above author.

"BE IT FURTHER RESOLVED that the editor of Reader's Digest be requested to recognize the injustice and the damage created by such an article in such an important journal as the Reader's Digest and a copy be sent to the House of Delegates of the KSMA."

This report, submitted by the Harlan County Medical Society, was discussed and it was felt that the Harlan County Medical Society should be complimented on its action regarding the Reader's Digest article, and that the House of Delegates should support them in this worthy cause.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that Resolution J be accepted.

Supplement B to the Report of the Chairman of the Council

This supplement was discussed at some length and the following recommendations were made: Since there is a conflict between the resolution presented by Doctor Gaithel Simpson and his committee (which is being studied by another Reference Committee) regarding the adequacy of the Code of Ethics in the ability to cope with certain situations in Kentucky, it is recommended that certain references to the Code of Ethics on page 2, paragraph 5 of Supplement B to the Council Report be deleted in order that there might be uniformity in this House of Delegates.

Mr. Speaker, I move the adoption of this supplement as amended.

The motion was seconded and carried that Supplement B to the Report of the Council be accepted as amended.

Mr. Speaker, I move the adoption of this report as a whole.

The motion was seconded and carried that the report of Reference Committee No. 1 be adopted as a whole.

Signing the report of Reference Committee No. 1 were: E. M. Howard, M.D., Harlan, chairman; Rankin C. Blount, M.D., Lexington, vice-chairman; H. E. Martin, M.D., Ashland; A. O. Miller, M.D., Louisville; J. L. Tanner, M.D., Henderson.

REFERENCE COMMITTEE NO. 2

Richard G. Elliott, M.D., Chairman

Reports on Medical Care, Medical Education, Hospitals and Related Subjects

Committee on Medical Service

The Committee reported its activities in lending assistance to the Legislative Committee and in complying with requests of the Council.

This report was studied and the committee is to be commended for its activities during the past year. Two meetings were held, one May 24 and the other July 12, 1956. Recommendations were made, at the request of the KSMA Council, to the Council and will be considered in its report to the House. These recommendations implement the request of the President, which was adopted by the House at the 1955 meeting, "that the House of Delegates instruct the Medical Service Committee to study our major unsolved problems, placing them in position of relative importance and reporting its findings to the Council. It is further moved that the Council be directed to bring to the House in 1956 positive recommendations as to how these problems are to be solved and a goal to be reached within the next 5 to 10 years."

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Medical Service be adopted.

Committee on Hospitals

This committee held one meeting during the past year and at that time matters and problems pertaining to hospitals in Kentucky were thoroughly discussed.

This committee met on April 21, 1956 and discussed the following matters; (1) UMWA Hospitals are in the province of the KSMA Advisory Committee to the UMWA rather than in those of this committee. (2) There should be a minimum standard for practice in the hospitals of this state and these standards should vary according to the size of the hospital. (3) That lay hospital boards be condemned for the practice of deciding what percentage a pathologist or radiologist can make from his practice in the hospital. The committee recommends that hospitals should rent space and equipment at a sufficient cost to make it profitable to the hospital and that any profit above this should go to the pathologist or radiologist. Any change should be decided by the medical staff in conjunction with the administrator and lay board. (4) Hospital inspection should be done by qualified personnel of the AMA, but this committee should act in an advisory capacity to consult with any hospital or physician who desires help and advice.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Hospitals be adopted.

Physicians' Placement Service Committee

This report outlined the aims of the Physicians' Placement Service and itemized the progressive steps that have been taken to make placement listings available in an adequate and current form.

The Kentucky State Medical Association operates a physicians placement service to young doctors seeking a place to locate and to Kentucky communities in need of professional talent. Three basic principles are followed in this service: (1) The community asking assistance in locating a physician is cleared by the local county medical society secretary of the KSMA councilor for the district. (2) Each community must furnish standard information designed to give the prospective physician a clear picture of what he may expect. (3) The physician seeking placement must give complete data on his training and background, availability and objectives. The service keeps up-to-date lists of communities rated "in need" and of physicians seeking locations. Towns under the 1,000 population mark and with a priority rating "A" for need seem to lack acceptability to the applying physician and his family. The Chairman of the committee met with Governor A. B. Chandler and the Rural Scholarship Committee at the invitation of Dr. C. C. Howard at Frankfort on May 31, 1956 and discussed the placement problem. Mr. John Guy Miller of the staff of KSMA will be called upon to try to help communities to use the priority rating plan and to realize their shortcomings. In the past year, 70 communities and physicians have been assisted by the Kentucky Physicians Placement Service.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Physicians' Placement Service Committee be adopted.

Committee on Postgraduate Medical Education

Although only one formal meeting was held during the year, this committee has been effective in stimulating an interest in postgraduate courses which have been made available to all sections of the state.

A formal meeting of the committee was held on December 1, 1955. It was agreed that the committee should strive to develop an adequate and effective program of post graduate courses which could be taken into each section of the state within easy traveling distance of all KSMA members. It is further agreed that such a program must, of necessity, move slowly and that a given section of the state should be selected in which two or three trial runs would be held. The ensuing activities have been participated in by the committee to date: (1) Harrodsburg Seminar, to be held in March each year. (2) The KSMA cooperated with the University of Louisville in sponsoring the "Spring Postgraduate Series" at General Hosptial. (3) Maysville Postgraduate Seminar in conjunction with the 9th Councilor District Meeting. (4) The association cooperated actively with the annual Pediatrics Seminar presented by the Children's

Hospital, Louisville, in May and June. (5) Arranged a scientific program and joint meeting of the 12th and 15th Councilor Districts at Cumberland Falls in June. (6) The committee will cooperate with the State Tuberculosis Commission in its postgraduate program.

Mr. Speaker I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Post Graduate Medical Education be adopted.

Medical School Advisory Committee

It was not necessary for the Chairman to call any meetings of this committee during the past year.

No meeting was held by the committee during the past year. The Medical School graduated 93 members in the Senior class—77 from Kentucky. One hundred seven freshmen have been accepted for admission this year—97 from Kentucky.

Dean Kinsman has carried out the suggestion of the Committee with reference to a Medical School Newsletter. Three of these letters have been sent through the Alumni office, and on one occasion the addressing facilities of the KSMA were employed. The committee recommends this newsletter be continued and enlarged.

Mr. Speaker I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee to the Medical School be adopted.

Committee on Nurse Training

This committee held one meeting during the past year.

The committee, after consulting with the State Board of Health, felt that it was permissible for nurses to give intravenous injections under the direction of or by the order of a Doctor of Medicine, and that nurses should be taught to give such injections during their training period.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Nurse training be adopted.

Professional Relations Committee

This committee did not consider it necessary to hold a meeting during the past year, but one will be held sometime during the State Medical Convention for the purpose of clearing up any unfinished business that might have accumulated during the year.

No meeting has been necessary during the year as there has been a marked decrease in the number of complaints. This is due to the formation of similar committees by county medical societies, which handle these matters locally, and to better understanding between the public and the profession generally.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Professional Relations Committee be adopted.

Resolution E—Regulation of Fees

"WHEREAS, there is a movement by the health insurance industry, the Blue Shield organization, some officials of the AMA, the Federal government and some members of the KSMA to establish a nation-wide fixed fee schedule for medical-surgical services,

"WHEREAS, the Kentucky Blue Shield at the time of its incorporation by the KSMA and quite recently has promoted the adoption of a service plan to replace the present indemnity plan.

"WHEREAS, these two approaches toward socialized medicine are of such an important nature that mature consideration should be given them and action on them should not be taken by a simple majority vote of the House of Delegates, but should be subject to the same rules which govern adoption of amendments to the constitution; viz., a two-thirds majority vote of the House of Delegates with a year elapsed between proposal and vote for consideration by all members of the KSMA, therefore be it

"RESOLVED that Article II of the constitution be amended by inserting after the last sentence the following:

'The Association shall take no action in pursuance of these or any objectives which will directly or indirectly regulate or attempt to regulate physicians' fees.' "

This Reference Committee after much discussion felt this resolution lacks flexibility and would embarrass the KSMA in future discussion and action connected with physicians' fees. The Committee recommends that the proposed constitution amendment be amended to read: Resolved that Article II of the Constitution be amended by inserting after the last sentence the following:

> "The Association shall take no action in pursuance of these or any objectives which will directly or indirectly regulate or attempt to regulate physicians' fees except by a ⅔ majority vote of the House of Delegates."

Mr. Speaker I move the adoption of this section of the report as amended.

The motion was seconded and carried that the resolution (#E) on the regulation of fees, submitted by the Fayette County Medical Society, be accepted as amended.

The Speaker pointed out that the above resolution would now have to lay over for one year.

Council Resolution—University Of Kentucky Medical School

"WHEREAS, the Board of Trustees of the University of Kentucky has established a medical school at Lexington, and

"WHEREAS, the initial steps have been taken toward the planning and building of such a medical school, including the appointment of a dean, now therefore

"BE IT RESOLVED, by the House of Delegates of the Kentucky State Medical Association that official

notice be taken of this action and that a letter be written to the President of the University and the Dean of the Medical School commending them on this step in medical education and assuring them that the House of Delegates stands ready to aid and cooperate in any way possible in the interest of improved health and expanded medical education in this commonwealth."

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the Council Resolution re the University of Kentucky Medical School be adopted.

Reference Committee No. 2 wishes to commend the committees and their chairmen on the hard work and thought which have gone into the formulation and implementation of their committees' work. The Chairman of this reference committee wishes also to thank the members of his committee for their help and cooperation in the preparation of this report.

Mr. Speaker, I move the acceptance of this report as a whole.

The motion was seconded and carried that the report of Reference Committee No. 2 be accepted as a whole.

Signing the report of Reference Committee No. 2 were: Richard G. Elliott, M.D., Lexington, chairman; Chris Jackson, M.D., Danville, vice-chairman; John D. Handley, M.D., Hodgenville; W. Burford Davis, M.D., Louisville; Marc Reardon, M.D., Covington.

REFERENCE COMMITTEE NO. 3

Carl H. Fortune, M.D., Vice Chairman

Reports on Legislation and Public Relations

Report of the Committee on Public Information & Service

The Committee on Public Information and Service has this year replaced the Education Campaign Committee which had functioned so efficiently for the past four years. Usually one major project is started and developed throughout a year. At the present time an indoctrination leaflet is being prepared for distribution to each KSMA member and to each new physician as he receives his state license. This leaflet will be entitled "Your Activities In KSMA." Other major activities of this committee were the continuation of "News Capsules," which is brief enough to promote maximum reading, the PR Courses for secretaries and assistants of doctors (with total attendance of 172); the Second Senior Day Program at the University of Louisville School of Medicine; the "Exhibit," which this year was sponsored jointly with the Committee on Public Health and had as its theme "Immunization; health exhibits sponsored by the AMA and obtained from the state Headquarters Office upon request; and distribution of AMA leaflets, radio transcriptions and motion pictures.

The report of the Committee was studied and the excellent work was noted.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Public Information and Service be accepted.

Report of the Medico Legal Administrator

In his report the Medical Legal Administrator points out that only a few physicians are sued. In connection with a study being conducted by the Legal Department of the AMA to determine the background of professional liability suits, the Administrator has reviewed twenty-five cases in Kentucky.

The Committee wishes to call attention to the following section of this report and call it to the careful consideration of all members of this Association. We commend the Administrator on his excellent report.

> "Twenty-five cases were reviewed in which complete files were available. Of these twenty-five cases, seven were due directly to an opinion expressed by one doctor regarding previous treatment of the case by another physician. Two were purposely malicious. If this represents the overall picture, the concern of the American Medical Association over this particular cause of malpractice suits is easily understood."

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Medico-Legal Administrator be adopted.

Committee on Corporate Practice of Medicine

This committee had little activity during the year. It had been asked to submit a definition of 'corporate practice' but after considerable thought and consultation deferred compliance until after the clinical session of the AMA on November 27-30, when final action is to be taken on the revised version of medical ethics, and, also, until after final settlement of the litigation between Iowa State Medical Association and the Iowa Hospital Association. Both events will strongly influence any definition by the KSMA.

The Ex. Committee expresses appreciation for the Committee's work and agrees that the definition of corporate practice requested by the 1955 session of the House of Delegates should be delayed until after legal action in the State of Iowa is completed and until after the AMA Code of Ethics is revised.

Mr. Speaker, I move the adoption of this report.

The motion was seconded and carried that the report of the Medico-Legal Administrator be adopted.

Legislative Committee

The Legislative Committee kept a close watch of and took an active interest in the activities of the General Assembly and worked hard to support legislation which would benefit the health and welfare of Kentuckians. This committee held four meetings during the year and also met with other groups when necessary.

The Committee wishes to call attention to the recommendation of the Legislative Committee that a special department be added to the KSMA News Capsules as needed to inform

members fully of state and national legislative matters. We believe this is a worthwhile suggestion. We wish to express our appreciation for the work of this Committee.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Legislative Committee be adopted.

Committee to Study the Medical Examiner System

It is the consensus of opinion of this committee that its previous reports as well as those of its predecessor committees have expressed fully the feelings of the present members of the committee. The committee's primary recommendations were: (1) The present coroner system be replaced by an adequately conceived medical examiner system, which would require changes in the Constitution of the Commonwealth of Kentucky. Until this can be accomplished, it is the tenor of the present committee that a sound approach to the problem as presented is one of compromise and a concerted effort on the part of the KSMA to supplement the present coroner system and to make available to coroners of the state modern scientific methods for investigation. (2) The committee recommends that the Kentucky Medical Association, through appropriate channels, initiate and support legislation for creation of a state laboratory for the investigation of all unnatural deaths occurring within the boundaries of the state.

The Committee spent considerable time considering this report and expresses sincere appreciation of the concrete suggestions which have been presented. The report recommends that the Kentucky Medical Association, through appropriate channels, initiate and support legislation for creation of a state laboratory for the investigation of all unnatural deaths occurring within the boundaries of the State. It then goes to delineate the functions and purposes of this laboratory. It points out that the coroner system is a part of the Constitution of Kentucky and that any system must work under the present framework unless the Constitution is changed. It further recommends that consideration be given to the establishment of this laboratory in Louisville in connection with the University of Louisville.

There was also presented to the Committee during the discussion, the Model Post-Mortem Examinations Act drafted by the National Conference of Commissioners on Uniform State Laws.

The Committee did not feel that it was possible to present to this meeting of the House of Delegates a definite recommendation for legislation. It was felt that the matter of Post Mortem Examinations Act should be carefully studied. It was further felt that since a State University School of Medicine is being established, consideration should be given to this institution in the establishing of a state laboratory.

Mr. Speaker, I recommend that this report be referred to the Council of the Kentucky State Medical Association for further study, and that it be presented at the next regular House of Delegates with recommendations for the initiation of legislation. Mr. Speaker, I so move.

The motion was seconded and carried that the Report of the Committee to Study Medical Examiner System be referred to the Council of the KSMA for further study and that it be presented at the next regular House of Delegates with recommendations for the initiation of legislation.

Veterans Committee

This committee reported that the contract between KSMA and Veterans Administration for "Home Town Medical Care" of service connected disabilities, as revised in 1955, has been renewed in 1956. The committee recommended that all members of KSMA congratulate their Congressmen and Senators for the work they have done in preventing waste and abuse of the VA funds for unwarranted pensions and urged that everything possible be done for adequate medical care and pensions for veterans with service connected disabilities only.

The Reference Committee expresses appreciation of the work of this Committee and notes that there are no definite recommendations to be acted on.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Veterans Committee be adopted.

Report of the Advisory Committee on United Mine Workers Welfare and Retirement Fund

The opening of the Memorial Hospitals of the UMWA is producing changes in medical practice in Eastern Kentucky. While it is not possible to completely evaluate these changes at this point, there are definitely certain elements of controversy between the Fund and the physicians of Eastern Kentucky. The efforts of this committee have been largely directed to trying to delineate the problems and if possible accomplish adjustment of some of the differences.

The committee recommended: (1) The principle already adopted should be reaffirmed; namely, "We believe that free choice of physician among ethical and qualified individuals and fee for service payment is in the best interest of good medical care." (2) The making by a physician of ward rounds on the patients of another physician without his request or consent and without the request of the patient, is unwarranted interference in the doctor-patient relationship and is to be condemned. (3) Subsidy payments intended to induce physicians to participate in any health program are to be condemned if they in any way lead to monopoly or control of medical practice in an area, or if there is exploitation either of the public or the physicians involved. (4) The county medical society is an autonomous unit. It has the right to refuse membership to individuals if it considers these individuals to be engaged in practices which are unethical. A difference of opinion on the most desirable method of medical practice does not necessarily imply that either method is unethical. It is hoped that the differences can be resolved on the local level. If this is not possible it is recommended that the House of

Delegates approve the reference of the differences to the Subcommittee on Medical Care of Industrial Workers of the American Medical Association.

The Reference Committee considered at great length the problems of the physicians in Eastern Kentucky. It wishes specifically to call attention to the recommendations, which have already been summarized above.

Mr. Speaker, I move the adoption of this section of this report.

The motion was seconded and carried that the report of the Advisory Committee on United Mine Workers Welfare and Retirement Fund be adopted.

Report of the Council (portion of)

This portion of the Report of the Council concerns the disagreement between the UMWA Welfare and Retirement Plan and members of the medical profession in Eastern Kentucky. This was referred to the Advisory Committee of the UMWA Retirement Fund and is covered in Report #53.

Mr. Speaker, I move the adoption of this section of the Council Report.

The motion was seconded and carried that the above portion of the Council report be adopted.

Council Resolution—Code of Ethics

"WHEREAS, it has come to our attention that the American Medical Association recognized that per se the practice of medicine by salary or subsidy is ethical.

"WHEREAS, it has also come to our attention that salary with exploitation is unethical; that subsidy with the interest of control is unethical; that total community care which eliminates the element of free enterprise making competition is impracticable

"WHEREAS, since the judicial council of the AMA is now making a study of the Code of Ethics with the expectation of recommending certain changes in the Code of Ethics, be it therefore

"RESOLVED, that the Kentucky State Medical Association request the Judicial Council of the AMA to include in its report on the Code of Ethics of AMA recognition of the above mentioned abuses of ethical medical practice and condemnation in the Code of Ethics of the above named dangerous abuses of medical practice;

"BE IT FURTHER RESOLVED, that the Kentucky State Medical Association House of Delegates feels that should the proper recognition of these insidious violations of the Code of Ethics be stated by the Judicial Council, it will greatly deter abuses of the Code of Ethics."

The Committee feels that this is an excellent presentation of the highest ethical approach to the difficult problem of the practice of medicine by salary or subsidy.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the Resolution of the Council on a Code of Ethics was adopted.

Resolution K—Unethical Practices

"The Pike County Medical Society at its regular meeting on September 11, 1956 passed the following resolution concerning the ethical practice to be presented to the Kentucky State Medical Society House of Delegates for their consideration.

"The use of salary payments to practicing physicians for services rendered is unethical.

"This conclusion is based upon an analysis of certain policies by organizations pertaining to the practice of medicine in Pike County, Kentucky.

"Salary payments as implementation of these policies are unethical by reason of the following considerations:

1. These payments produce conditions of subsidizing one physician while censuring the fees of the independent practitioner.
2. These lead to the practice of fee splitting with a third party.
3. These create exploitation of physicians.
4. These place the salaried physician in the unethical position of advertising by reason of advertising by the third party and its instruments.
5. These interfere with the freedom of the physician to act as an individual.
6. These pervert the concepts of charity."

This is a resolution presented by the Pike County Medical Society concerning the same problem considered by the resolution of the Council above. The Committee feels that the problems presented in this resolution are covered in the resolution of the Council. The Committee further feels that this resolution is too broad in that it states, "the use of salary payments to practicing physicians for services rendered to patients is unethical."

Mr. Speaker, I move that this resolution be not approved.

The motion was seconded and carried that Resolution K on Unethical Practices, submitted by the Pike County Medical Society, be not approved.

Supplement "A" to the Council Report

In accordance with the provision of Public Law 569, 85th Congress, which makes available Medical care for military dependents and which goes into effect December 8, 1956, the Council wishes to point out the following facts.

When this law was enacted, the Defense Department came to organized medicine with the request that medicine work with the Department in implementing the law. It is understood that the Department of Defense was not obligated to do this and is empowered to develop its own program without consultation with the medical profession.

It should be emphasized that the Department of Defense working with the American Medical Association is requesting three things: First, that the State Medical Association become the contractural agent with the Defense Department to provide medical care for military dependents; Second, that the State Medical Association name a fiscal agent whose duty it would be to receive and pay out Government funds in implementing this program; and third, that it submit by October 1, 1956 a fee schedule covering some two procedures called for in the Uniform Nomenclature listed.

There followed a list of approximately 200 of the *more common* procedures and the *maximum* fees

(Continued on Page 1080)

ACHRONYCH



ACHROMYCIN*

Hydrochloride
Tetracycline HCl *Lederle*

in the treatment of

genitourinary infections

UROLOGISTS report the decided advantages of oral efficacy, minimal side effects, and wide range antibacterial activity offered by ACHROMYCIN in the treatment of urinary tract infections.

Finland's[1] group of patients with acute infections of the urinary tract (principally *E. coli)* demonstrated excellent response, both clinical and bacteriological, following administration of tetracycline.

Prigot and Marmell[2] reported 49 out of 50 patients with gonorrhea showed a negative smear and culture on the first post-treatment visit. Purulent discharge disappeared in these patients within 24 hours after a usual 1.5 Gm. dose of tetracycline.

Trafton and Lind[3] found tetracycline (ACHROMYCIN) an effective antibiotic for treating many urinary tract infections caused by both Gram-negative and Gram-positive organisms.

English, *et al.*[4] noted that a daily dose of 1 to 1.5 Gm. of tetracycline resulted in urinary levels as high as 1 mg. per milliliter.

To suit the needs of your practice and to further the patient's comfort ACHROMYCIN is offered in a complete line of 21 dosage forms.



LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

Lederle

*REG. U.S. PAT. OFF.

References:
1. Finland, M., *et al.: J.A.M.A.* 154:561 (Feb. 13) 1954.
2. Prigot, A. and Marmell, M. *Antibiotics and Chemotherapy* 4:1117 (Oct.) 1954.
3. Trafton, H. and Lind, H.: *idem* 4:697 (June) 1954.
4. English, A., *et al.: idem* 4:441 (April) 1954.

(Continued from Page 1077)

recommended for these procedures in Kentucky, which the Defense Department has requested by October 1, 1956.

(This list is a part of the 113-page official format of uniform nomenclature, and represents the procedures that the Defense Department must have at this time. Recommendation on the balance of the list set forth in the 113-page uniform nomenclature must be submitted at an early date. The schedule listing the 200 items mentioned above is on file at the Headquarters office of KSMA and is available to all KSMA members.)

The Council of KSMA moved to submit this report of fee schedule to the House of Delegates with approval and a word of compliment to the Committee on Medical Care for Military Dependents and its Chairman, Robertson O. Joplin, M.D., for diligent work in its preparation and approved in principal the cooperation of the KSMA with the Department of Defense in carrying out the program for medical care for dependents and also approved the Blue Shield as fiscal agent for carrying it out in Kentucky, and that KSMA become the contractual agent.

The Committee considered Supplement "A" in considerable detail. This report states that the State Medical Association shall become the contractual agent with the Defense Department to provide medical care for military dependents. It then goes on to list a considerable number of procedures with suggested fees. The Committee recommends before final fees are settled upon that, if possible, conference be held with various specialty groups and with the Kentucky Academy of General Practice with regard to these fees. The report then closes with a motion which states in part:

". . . we approve in principal the cooperation of the KSMA with the Department of Defense in carrying out the program for medical care for dependents and that we also approve the Blue Shield as fiscal agent for carrying it out in Kentucky, and that the KSMA become the contractual agent."

The Committee wishes to commend Robertson O. Joplin, M.D., for his diligent work in the preparation of this report. The Committee feels, however, that for the sake of clarity the phrase "Kentucky Physicians Mutual, Inc." should be substituted for "Blue Shield" in the motion stated above.

Mr. Speaker, I move that the motion be rephrased so that it says ". . . we also approve the Kentucky Physicians Mutual, Inc., as fiscal agent for carrying it out in Kentucky."

The motion was seconded and carried that this amendment be adopted.

Mr. Speaker, I move the adoption of this report as amended.

A lengthy and involved discussion followed in which the following additional amendments were moved and seconded: (1) The Committee on Medical Care for Military Dependents shall be empowered to consider recommendations from various specialty groups and from the Kentucky Academy of General Practice provided these recommendations be in the hands of the committee by October 1. (2) The word 'maximum' should be deleted from the introductory sentence of the recommended fee schedule. These amendments carried.

The motion to adopt the Supplement "A" as amended was seconded and carried.

Resolution "F"— Essay Contest

"WHEREAS, the Association of Physicians and Surgeons each year for eleven years has sponsored a national essay contest for high schools on the advantages of private medical care and has for the 1957 contest seen fit to offer a second choice of subject, namely, the advantages of the American free enterprise system, and offer $1,000 first prize, $500 second prize, $100 third prize, and $25 each for fourth, fifth and sixth prizes,

"RESOLVED, that the Association of American Physicians and Surgeons feels that this is a very worthy contest and prays that the Kentucky State Medical Association House of Delegates will approve the contest so that it may be offered with the State Medical Association's blessings."

This is a resolution submitted by A. L. Cooper, M.D., of Pulaski County. It requests approval of the House of Delegates for essay contests being conducted by the Association of Physicians and Surgeons on the advantages of the American free enterprise system. It is the feeling of the Committee that to endorse such a project would be endorsing the aims and purposes of the Association of Physicians and Surgeons. Since the Committee is not sufficiently familiar with the Association of American Physicians and surgeons to form an intelligent opinion, it is recommended that further study be given to this matter by the Committee on Public Information and Service.

Mr. Speaker, I move that this report be referred to the Committee on Public Information and Service, to be reported back to the next meeting of the House of Delegates.

The motion was seconded and carried that Resolution "F" be referred to the Committee on Public Information and Service for study and report to next year's House of Delegates.

Resolution "I"
Kentucky Exposition Center

"WHEREAS, the state of Kentucky has in its new Exposition Center at the Fairgrounds, modern facilities which are unmatched in their unique attraction for the year round promotion of fairs, sporting events, conventions and other entertainment, and

"WHEREAS, it is planned that a portion of this Exposition will be used for the year around display of products and services in a manner that will be educational and attractive to the many guests who will be in attendance, and

"WHEREAS, it is quite apparent that this Exposition Center is destined to contribute widely as an influence not only in the lives of many people from Kentucky but from all over the United States, therefore

"BE IT RESOLVED, that the House of Delegates of the Kentucky State Medical Association instructs the Council of the state association to study the advisability of obtaining permanent space at this Exposition Center for the year around display of exhibits and material that would add to the prestige and influence of medicine in the State of Kentucky."

This is a resolution presented by the Jefferson County Medical Society instructing the Council to study the advisability of obtaining permanent space at the Exposition Center for year around display of exhibits and material that would add to the prestige and influence of medicine in the State of Kentucky.

It is also reported to the Committee that the cost of such space would amount to approximately $500 a year without provision for the cost of exhibits or for the maintenance of the exhibit space. The Committee feels that the annual exhibit at the Kentucky State Fair is well worthwhile but that the advisability of a permanent exhibit is questionable, particularly in view of the considerable expense which might be involved.

Mr. Speaker, I recommend that this resolution be not adopted.

The motion was seconded and carried that Resolution "I" be not adopted.

Mr. Speaker, I move the adoption of this report as a whole.

The motion was seconded and carried that the report of Reference Committee No. 3 be accepted.

On the basis that new business may be submitted at the final session if it is done so with the unanimous consent of the House, a motion was made and seconded that Resolution "B," introduced by the Jefferson County Medical Society for the Reapportionment of Councilor Districts, be resubmitted as a proposed amendment to the Constitution. Unanimous consent was not given.

Signing the report of Reference Committee No. 3 were: Carl H. Fortune, M.D., Lexington, vice-chairman (presiding); Ralph D. Lynn, M.D., Elkton; Norman Adair, M.D., Covington; S. E. Farmer, M.D., Brownsville; R. W. Robertson, M.D., Paducah.

REFERENCE COMMITTEE NO. 4

T. O. Meredith, M.D., Chairman
Reports on Miscellaneous Business

Diabetes Committee

This report announced that 122 new cases of diabetes were detected in the 1955 drive, and 806 cases during a 5-year period. Twelve counties have done over 1,000 tests. The committee hopes for better support from KSMA members in future drives. Thanks was extended to the Ames Company, radio stations, television stations, newspapers and journals who supported the program. The next drive will be November 11-17.

We wish to commend the Committee for this report.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Diabetes Committee be adopted.

Dietetic Committee

There have been no new developments in the program of the standard diet manual for use in the hospitals in the State.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Dietetic Committee be adopted.

McDowell Home Committee

This report states that the affairs of the McDowell Home had progressed satisfactorily. Road signs are all still up, the house has been painted, roof repaired and upkeep maintained. The house is furnished entirely in antiques—valuation $23,000. The total assets of the McDowell Home are $50,237. The committee thanked the KSMA for its appropriation of $1,500 and the Kentucky Surgical Association for its donation of $1,000. Thanks were also expressed to the Woman's Auxiliary to KSMA for the care given the gardens.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the McDowell Home Committee be adopted.

Advisory Committee on Industrial Medicine & Surgery

This report comments on the increase of industry and the increasing responsibility that is imposed on all Kentucky physicians and requests their cooperation with the State Board of Health in new Health regulations.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee on Industrial Medicine & Surgery be adopted.

Advisory Committee on Mental Hygiene & Mental Institutions

This report deals with the various clinics and institutions that operate in Kentucky. Mention is made that the Subcommittee on Alcoholism has been very active. The State Mental Hospital Program is progressing satisfactorily. The following comments were of especial interest:

(a) There has been a decrease in the cenus of the hospitals during the past year.
(b) Tuberculosis Centers are planned at Eastern and Central State Hospitals.

(c) A Children's Ward has been established at Central State Hospital and a special staff devotes full-time to the children's project.
(d) Five research studies have been directed to evaluate various new ataraxic drugs.
(e) Personnel officers have been added in each hospital for recruiting, screening, and orientation of new employees.
(f) A Student Nurse Affiliation was established at Western State Hospital.
(g) Teaching seminars were sponsored for employees.
(h) A consultant in dietetics was employed.
(i) A consultant in Psychiatric Nursing was employed.
(j) A cooperative venture between Western State Hospital and the Public Health Nurses was planned to provide follow-up service for discharged patients through regular visits by these nurses.
(k) A part time clinic was opened in Ashland.
(l) $100,000 was obtained from the Governor's Emergency Fund; drugs were purchased and a statistical evaluation is being made of these drugs.

The Committee also commended the excellent work of the Commissioner of Mental Health and said that he has been most cooperative while working with and advising the committee.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee on Mental Hygiene & Mental Institutions be adopted.

Advisory Committee on Public Health

This Committee urges all physicians to maintain good immunization records and urges, also, the continuation of Immunization Week in Kentucky and endorsement of the Immunization Act. Progress has been made in the development of a cooperative accident prevention education program in coordination with the Kentucky State Department of Public Instruction, the Kentucky State Department of Health and other interested groups. Work of the Committee has borne fruit in the decision of the Governor and Legislature to create a Department of Safety in the State government.

The Committee wishes to urge all physicians to keep up good immunization records and urge full endorsement of the Immunization Act in Kentucky. We wish to thank the Committee for its influence on the Governor for creating a new Department of Safety.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee on Public Health be adopted.

Advisory Committee to the Blue Cross

The Advisory Committee to Blue Cross usually meets once a year—at the time of the KSMA Annual meeting. Such a meeting is planned for 1956. The Chairman of the Committee maintains relatively close contact with the officials of Blue Cross and meets with them about four times yearly to discuss problems of mutual concern. These problems are conveyed to the profession, usually by letter, which to date has been satisfactory to the physicians.

We wish to commend the Committee for its excellent work and hope it will continue to inform all members of the KSMA on further developments.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee to Blue Cross be adopted.

Advisory Committee to the Woman's Auxiliary

The Woman's Auxiliary to the Kentucky State Medical Association has not requested any advice and no meetings of the Committee were held.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee to the Woman's Auxiliary be adopted.

Resolution "A"
American Medical Association Dues, Mandatory

"WHEREAS, the activities and accomplishments of the American Medical Association in their many fields of endeavor are ever increasing in scope and benefit to the entire medical profession, and

"WHEREAS, each physician benefits by the work of the officers, councils, bureaus and departments in such worthwhile programs as medical education, internship and residency training, physician placement, scientific publications, package library service, scientific meetings and exhibits, guidance on drugs, cosmetics and foods, information on quacks, hospital standards, research assistance, public relations, legislation, health education, medico-legal problems, physicians directory, ethical practices and others,

"WHEREAS, the national association is of unlimited benefit to the state and county societies in such matters as exhibits, journal advertising, medical films, public relations projects, conventions plans and programs, assistance to the over-all planning of many programs, and the source of untold amounts of factual information, and

"WHEREAS, the position of the profession in matters of science and legislation becomes increasingly important from year to year. It is well known that the American Medical Association has served the public for many years in the field of legislation by advocating the passage of laws to protect their health and opposing such legislation as may not be in the best interests of good medical care. The public is served in many ways through the American Medical Association work in education, investigation and information, and

"WHEREAS, the vast majority of members of this association are now members of the American Medical Association, and

"WHEREAS, many states, such as Arizona, California, Colorado, Illinois, Mississippi, Nebraska, Nevada, Oklahoma, and Wisconsin, subscribe to the belief that American Medical Association membership is equally important to that of the state and county societies, thus establishing organized medicine as a truly representative association from the county to the National level, therefore be it

"RESOLVED, that this House of Delegates instruct the Council of the state association to study the advisability of an amendment to Section I, Chapter IX of the Association's bylaws which would require membership in the American Medical Association as well as the county society in order for a physician to belong to this association, and

"RESOLVED, that after study the Council report back to the House of Delegates at the 1957 session with recommendations concerning mandatory American Medical Association membership.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that Resolution "A," submitted by the Jefferson County Medical Society, be adopted.

Mr. Speaker, I move the adoption of this report as a whole.

The motion was seconded and carried that the report of Reference Committee No. 4 be adopted.

Signing the report of Reference Committee No. 4 were: T. O. Meredith, M.D., Harrodsburg, chairman; W. E. Becknell, M.D., Manchester, vice-chairman; Robert S. Dyer, M.D., Louisville; T. R. Davis, M.D., Barbourville; John Allen, Jr., M.D., Louisville.

REFERENCE COMMITTEE NO. 5

Roy H. Moore, M.D., Chairman
Reports on Miscellaneous Business

Committee to Study the Constitution & Bylaws

This report sets forth changes in the Constitution and Bylaws as recommended by the Committee.*

The Committee recommends the change as proposed in Chapter VI, Section 6; the change as proposed in Chapter VI, Section 7; the change as proposed in Chater VII, Section 7; and the change as proposed in Chapter VII, Section 11. The Reference Committee carefully considered Report No. 4, Supplement No. "C" to the Report of the Council of the KSMA and heard considerable testimony regarding this supplemental report, but it was the unanimous decision of the Reference Committee to follow the recommendation of the Committee to study the Constitution and Bylaws relative to the wording of Chapter VII, Section 11. The Committee recommends the change as proposed in Chapter VII, Section 1, except that the following sentence, "Said Executive Committee shall exercise all the powers delegated to the Council between sessions of said Council, except those powers specifically reserved by the Council for itself," which the Committee proposed to be added to the end of this section, be changed to read "Between sessions of the Council, the Executive Committee shall exercise all of the powers belonging to the Council except those powers specifically reserved by the Council to itself." This Committee recommends the change as proposed in Chapter VIII, Section 1, the changes as proposed in Chapter VIII, Section 2; the change as proposed in Chapter VIII, Section 3; the change as proposed in Chapter IV, Section 4; the change proposed in Chapter XII, Section 8; and the change as proposed in Chapter VII, Section 6.

Mr. Speaker, I move the adoption of this section of the report.

After discussion, the motion was seconded and carried by a two-thirds majority that the report of the Committee to Study the Constitution and Bylaws be accepted.

World Medical Association Committee

The Committee wishes to encourage all physicians in Kentucky who can to join this worthwhile medical organization. The activity of the World Medical Association joined with the United Nations makes a strong organization for the advancement of medical science throughout the world.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the World Medical Association Committee be adopted.

Committee to Study the Committee & Organizational Structure of KSMA

The creation of this committee was authorized by the House of Delegates in 1955 for the purpose of studying and recommending changes that would improve the committee and organization structure of KSMA. The committee recommended a regrouping of the Association's committees into main committees and subcommittees; namely, House of Delegates appointed, Council appointed, and president appointed. The committee also suggested several other changes.

Your Reference Committee has carefully studied the report of the Committee to Study the Committee and Organizational Structure of the KSMA to the 1956 session of the House of Delegates. Your Reference Committee approves the proposed regrouping of the association's committees into main committees and subcommittees under the three appointing authorities as listed in the report with the following exception: Report No. 4, Supplement No. "D" to the Report of the Council of the KSMA to the House of Delegates was carefully considered. This report recommended that the Legislative Committee be appointed by the Council rather than the Speaker of the House of Delegates. Your Reference Committee suggests that this recommendation of the House of Delegates be carried out so that the Committee on Legislation be appointed by the Council rather than the House of Delegates. This reference committee recommends the change as proposed in Chapter VIII, Section 1; the change as proposed in Chapter VIII, Section 5; the change as proposed in Chapter VIII, Section 6. Your Reference Committee recommends that the change in Chapter VIII, Section 7, be deleted and that Chapter VIII, Section 7 remain the same as written in the existing bylaws. Your Reference Committee approves the last paragraph of this report which recommends that the

The Constitution and Bylaws, as amended, will be found on page 1100 of this issue of The Journal.

World Medical Association Committee be abolished.

Mr. Speaker I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee to Study the Committee and Organizational Structure of KSMA be adopted.

Advisory Committee on Blood Banks

No problems in blood banking have been referred to the State Committee and, consequently, a meeting of this committee has not been necessary.

Attention of the Association is called to the function of this Committee on Blood Banks and it is recommended that local problems in blood banking be referred to the Advisory Committee on Blood Banks. This Reference Committee suggests that the Chairman of this Committee contact the local societies, informing them of the purpose for which this Committee was organized.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee on Blood Banks be adopted.

Advisory Committee on Cancer

Since no matters were referred to this committee during the past year, no formal meeting of the committee was held. Each member was contacted by letter and the committee feels the following facts should be entertained: (1) Cancer is the fifth major cause of death in Kentucky. (2) Kentucky should assume the care of indigent cases in the State. (3) Kentucky should have two or three well-organized, well-equipped treatment centers, strategically located, dedicated soley to the treatment and management of malignant disease.

This Reference Committee has studied this report and recommends that the Report of the Cancer Committee be resubmitted after careful review of the existing program of the Kentucky Division of the American Cancer Society.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee on Cancer be accepted.

Advisory Committee on Crippled Children

Since no matters have been referred to this committee for consideration during the year, no meetings were held. So far as is known, the work of the official State agency, Kentucky Crippled Children's Commission, has proceeded at its usual pace.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee on Crippled Children be adopted.

Advisory Committee on General Practice

At its formal meeting this Advisory Committee discussed the following topics: (1) Passage of legislation by the AMA and KSMA for the establishment of General Practice Sections in all hospitals and medical schools. (2) At least one general practitioner be on the Blue Cross—Blue Shield Committees. (3) A preceptorship system be reestablished in the Medical School at Louisville.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee on General Practice be adopted.

Advisory Committee on Pediatrics

Projects which this committee was formerly interested in are now being handled by other KSMA committees. These include accident and poison prevention and school health. The committee recommends that the House of Delegates instruct the appropriate authority to definitely define the purposes and scope of its activities in order it may better serve the Association and its patients.

The report of the Advisory Committee on Pediatrics has been studied and attention is called to paragraph 3 recommending that the House of Delegates instruct the appropriate authority to definitely define the purpose and scope of the activities of this committee in order that it may better serve the Association and patients. Your Reference Committee recommends that this problem be referred to the Committee on Medical Service.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee on Pediatrics be adopted.

Advisory Committee on Tuberculosis

Since no action has been taken on the report of this committee, which was approved by the 1955 House of Delegates, that "a locked facility be established for the care of recalcitrant 'open' tuberculous patients," the committee feels this matter should again be brought to the attention of the Governor and Legislators at Frankfort.

The report of the Advisory Committee on Tuberculosis has been studied.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that this section of the report be adopted.

Rural Kentucky Medical Scholarship Fund

This report reviewed the activities of the Fund for the past year. A total of 295 loans was made or was in the process of being made at the time the report was prepared. A total of $50,000 for the Fund was assigned to the State Department of Health in the Governor's budget recommendations for the biennium from July 1, 1956 to June 30, 1957. The program of the Fund continues to make a threefold contribution: (1) worthy medical students are being helped to finance their way through medical school; (2) people in many rural areas of our State are receiving more adequate medical care; and (3) the medical profession is gaining good public relations.

The Reference Committee has studied this report carefully.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Rural Kentucky Medical Scholarship Fund be adopted.

Board of Directors of Kentucky Physicians Mutual, Inc.

This report concern the seventh year of operation of the plan. Attention is called to its continued rapid growth and its sound financial condition, together with a condensed financial statement. The success and continued growth has been due in no small measure to the efficient administrative and enrollment organization which has been available through affiliation with the Kentucky Blue Cross Hospital Plan, Inc. At the meetings of the Board of Directors and various committees actions were taken by the Board, as deemed necessary, and attention was called to other important matters. Among these were the appointment of a committee to restudy the subject of "Service vs. Indemnity Benefits," the appointment of a long-range planning committee, the matter of medical-surgical coverage for the dependents of Service personnel was discussed, and as a result of a suggestion made during the Annual Conference of Blue Shield and Blue Cross Plans a forum was presented by the Kentucky Physicians Mutual in Louisville, to which officers of State and County Medical Societies and the members of the Insurance Committee of KSMA were invited.

Your Reference Committee has studied this report carefully.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Board of Directors of the Kentucky Physicians Mutual be adopted.

Report of the President

This section of the President's report pertains to his suggestion that KSMA continue to have a physician as the official secretary of the organization.

Your Reference Committee has carefully considered this paragraph of the President's report and strongly endorses the recommendation contained therein.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that this portion of the President's report be adopted.

Report of the Secretary Pro tem (Recommendation)

"After serving as your Secretary-Editor these past months and observing the duties of both offices at close range, it is my opinion that the two positions should be separated."

This Reference Committee has studied this portion of the report and endorses this recommendation.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the recommendation of the Secretary Pro tem, relative to the separation of the offices of Secretary-Editor be adopted.

Report of the Editor Pro tem (Recommendation)

This recommendation is the same as that made in the report of the Secretary Pro tem.

This Reference Committee endorses the recommendation in this report, so that the position of Secretary-Editor be separated in order that the Editor will not be involved with the duties of the Secretary. The Committee to Study the Constitution and Bylaws has a specific recommendation on this matter.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the recommendation contained in the report of the Editor Pro tem be adopted.

Supplement "C" to the Report of the Council

"The Council recommends to the House of Delegates a change in the bylaws whereby the election of the Executive Secretary of KSMA be made with the approval of the Secretary of the KSMA."

As indicated in the first paragraph of this Reference Committee's report, which was on the Committee to Study the Constitution and Bylaws, this Supplement "C" was carefully studied and after considerable testimony it was the unanimous decision of this Reference Committee to follow the recommendation of the Committee to Study the Constitution and Bylaws relative to the wording of Chapter VII, Section 11.

Mr. Speaker, I move the adoption of this section of the report as amended.

The motion was seconded and carried that recommendation in Supplement "C" be handled as suggested in the Report of the Committee to Study the Constitution and Bylaws.

Supplement "D" to the Report of the Council

"The Council wishes to go on record as recommending to the House of Delegates that the Legislative Committee be appointed by the Council rather than by the Speaker of the House of Delegates as recommended in the report of the Committee to Study the Committee and Organizational Structure of the Kentucky State Medical Association."

Your Reference Committee carefully considered this recommendation which was carried out and which is contained in the Report of the Committee to Study the Committee and Organizational Structure of the KSMA.

Mr. Speaker, I move the adoption of this section of the report.

The motion was made and seconded that Supplement "D" to the Council Report be adopted.

Resolution "H"—Number of Delegates

"WHEREAS, Warren County has had more than 25 active members and only one delegate for many years.

"WHEREAS, it takes many years for counties of our size to increase as many as 13 members (which is the required number over multiples of 25) in order to obtain an additional delegate.

"RESOLVED, that the following part of Chapter XII, Section 12, of the KSMA bylaws, which reads as follows:

> "'Each component society may be represented by one delegate for each 25 members in good standing or major fraction thereof. Provided, however, that each component society shall be entitled to at least one delegate regardless of the number of members it may have . . .'

Be amended to read:

> "'Each component society may be represented by one delegate for each 25 members in good standing

plus one delegate for one or more members in excess of multiples of 25. Provided, however, that each component society shall be entitled to at least one delegate regardless of the numbers of members it may have . . .' "

Your Reference Committee has carefully studied this Resolution.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that Resolution "H," submitted by the Warren County Medical Society be adopted.

Mr. Speaker, I move the acceptance of this report as a whole.

The motion was seconded and carried that the report of Reference Committee No. 5 be accepted.

Signing the report of Reference Committee No. 5 were: Roy H. Moore, M.D., Louisville, chairman; Frank Duncan, M.D., Monticello, vice-chairman; Glenn W. Bryant, M.D., Louisville; George Riley, M.D., Covington; Charles F. Martin, M.D., Winchester.

REFERENCE COMMITTEE NO. 6

Leon Higdon, M.D., Chairman
Reports on Miscellaneous Business

Delegation to AMA

The Delegates to AMA presented a very complete report of their activities in that capacity for the past year. They attended the interim session at Boston as well as the Annual AMA Meeting in Chicago. Doctor Elmer Hess retired as President of AMA, Doctor Dwight H. Murray was inducted as President and Doctor David Allman of Atlantic City was named President—elect. Hospital accreditation, evaluation of graduates of foreign medical schools, private practice of medical school faculty members, federal aid to medical education and premature publicity on new drugs were among the major subjects acted upon by the House of Delegates of the American Medical Association at its 105th Annual Meeting, which was held in Chicago in June.

This Committee, as well as the members of the House of Delegates, has heard the splendid report of Doctors Clark Bailey and W. Vinson Pierce read to us by Doctor Bailey Monday night. We wish to commend our delegates to the American Medical Association for the splendid manner in which they have brought us up-to-date on the activities of the American Medical Association.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Kentucky Delegation to the American Medical Association be adopted.

Committee on Arrangements

The committee reported that arrangements for the development of the 1956 Annual Meeting of KSMA have long since been made and published. During the 1955 session of the House of Delegates the Committee to Study the Constitution and Bylaws was authorized to submit a proposal to the 1956 session that would abandon the Arrangements Committee and transfer the duties to the Committee on Scientific Assembly.

Mr. Speaker, we wish to recognize the vast amount of work and planning which has been necessary for the Committee on Arrangements and heartily commend them for the smooth manner in which their efforts are being carried out.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Arrangements be adopted.

Committee on Scientific Assembly

The Committee reported that it had begun work on this 1956 Annual Meeting immediately after the 1955 meeting. Two more specialty groups were added (Orthopedic and Radiologic), making a total of eleven. Other additions were three postgraduate refresher courses and scientific movies.

We wish to point to the very excellent scientific program which your Committee has prepared. The success of our meeting is due largely to their good work and their long preparation.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Scientific Assembly be adopted.

Cerebral Palsy Committee

This Committee did not meet during the past year. However, the chairman has been in frequent contact with the Cerebral Palsy Center and spoke before a regular meeting of the parents of patients under treatment by the Center.

Although this Committee had no meeting during the year, we wish to commend it for the present policy of keeping in contact and cooperating with the family or referring physician so far as possible. It is recommended that the Committee make an effort to have at least one meeting during the year. We respectfully point out the value of a close contact between the medical profession and these various lay committees which deal with health matters. Such close contact will help control their activities, fund raising drives, budget matters, etc.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Cerebral Palsy Committee be adopted.

Committee on Emergency Medical Service

This committee did not meet during the past year.

As this report points out, there has been no meeting of the Committee this year. However, I should like to say that as a former member of the Committee, a lot of work has been done by the Committee during the previous years. The work of the five mobile support groups throughout the year has remained active and is carrying out the planning of this Committee. We recommend that the major suggestion made by this Committee last year be adopted; namely, that the medical profession encourage

all people to have some accurate knowledge of their blood type and RH factor on a form that would obviate the necessity for repetition. Also, I should like to point out that 90% of the services of physicians in any emergency depends upon the physicians' knowledge of their subject. The other 10% can readily be worked out in time of emergencies. We should like to further recommend increasing efforts on the part of the medical profession on the matter of educating the public as to the value of such immunization as tetanus and typhoid toxoids.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Emergency Medical Service be adopted.

Insurance Committee

This committee held one meeting during the past year. There was discussion on Kentucky Physicians Mutual's place in the overall health insurance program; and a plan was presented whereby insurance companies could get the necessary information from hospital records to evaluate a claim without having unrestricted access to the patient's confidential record.

This report has been reviewed by your Committee, and we recommend acceptance of the report with the exception of paragraph four (of the "Plan") action which is deferred to Committee No. 3. This paragraph deals with amending the Kentucky State Medical Association Constitution, and, therefore, is deferred to Committee No. 3.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Insurance Committee be adopted.

Committee on Infant and Maternal Mortality

This committee held one meeting during the year, at which time it decided to present the following resolution to the House of Delegates:

"That this committee recommend to the House of Delegates of the Kentucky State Medical Association that a Maternal Mortality Committee be activated for the purpose of a study of maternal mortality and that a program be developed similar to programs in other states and that this study be continued for at least five years. It is suggested that the committee be composed of ten appointed members; that two of these be appointed for five years, two for four years, two for three years and two for two years and two for one year. Each succeeding year two members shall be appointed by the president of KSMA. Also, that the Director of the Division of Maternal and Child Health of the State Department of Health and one full-time member of all medical schools Obstetrical Department in the State of Kentucky be ex-officio members. It is further suggested that the KSMA president appoint one of the senior members as chairman and that the other senior member be co-chairman."

This Committee presents the following resolution: "That this Committee recommend to the House of Delegates of the Kentucky State Medical Association that a Maternal Mortality Committee be activated for the purpose of a study of maternal mortality and a program be developed similar to programs in other states and that this study be continued for at least five years."

Mr. Speaker, we recommend the adoption of this report and that the President appoint such a Committee as suggested by this resolution.

The motion was seconded and carried that the report of the Committee on Infant and Maternal Mortality be adopted.

Advisory Committee to Selective Service

This report states that the demand for physicians has been very light during the past year. The coming year indicates more action because many physicians will be discharged in early 1957. By July 1, 1957 the "Doctors Draft" law will expire and it is unlikely that it will be re-enacted. Young physicians will be inducted or encouraged to enlist. Insofar as possible, Kentucky men in key and isolated areas will be protected and encouraged to remain at present locations, unless replacements can be secured.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Advisory Committee to Selective Service be adopted.

Committee on Scientific Exhibits

This committee reported the number of exhibits and the spaces utilized were reduced, but it felt they would be in a better location for viewing than in the past.

Mr. Speaker, we recommend adoption of this report and urge all Kentucky State Medical Association members to view the scientific exhibits.

The motion was seconded and carried that the report of the Committee on Scientific Exhibits be adopted.

Woman's Auxiliary

The Woman's Auxiliary to the KSMA reported a very active year. At the 1956 National Convention of the Woman's Auxiliary to American Medical Association, which was held in Chicago, Mrs. Clark Bailey of Harlan was elected second vice president and Mrs. Karl Winter, immediate past president, is Southern Regional Chairman of the Public Relations Committee of the National Auxiliary. The Auxiliary expects to continue expanding during the coming year.

Mr. Speaker, we move the adoption of this report. We would like to point out that the Woman's Auxiliary has a membership of 1,051 with 60 new members in the current year. We should like to commend them for their zealous activities and thank them for their many efforts in our behalf.

The motion was seconded and carried that the report of the Woman's Auxiliary to KSMA be adopted.

Mr. Speaker, I move the acceptance of this report as a whole.

The motion was seconded and carried that the report of the Reference Committee No. 6 be accepted.

Signing the report of Reference Committee No. 6 were: Leon Higdon, M.D., Paducah,

chairman; Carl Pigman, M.D., Whitesburg, vice-chairman; Blaine Lewis, Jr., M.D., Louisville; Douglas Jenkins, M.D., Richmond; Robert J. Hoffman, M.D., Covington.

REFERENCE COMMITTEE No. 7

L. F. Beasley, M.D., Chairman
Reports on Miscellaneous Business

Committee for Contribution to American Medical Education Foundation

The chairman of this committee reported that he had attended the meeting of the National Committee of the American Medical Education Foundation where methods of raising funds were discussed. It was decided that the best method to follow was one of individual solicitation; however this did not prove very successful during the past year. The committee reported, also, that the Woman's Auxiliary to the AMA had been very active in behalf of the American Medical Education Foundation.

Mr. Speaker, I move the adoption of this report.

The motion was seconded and carried that the report of the Committee for Contribution to American Medical Education Foundation be adopted.

Committee on Geriatrics and Long-term Illness

No meetings of this committee were held during the past year and there is no business to report. The Chairman feels that this is an area of activity in which the Association should take an active and continuing interest.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Geriatrics and Long-term Illness be adopted.

KSMA Dental Committee

No new business was referred to this committee and it did not meet during the past year.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the KSMA Dental Committee be adopted.

KSMA Pharmacy Committee

No meetings were held and no business was transacted by this committee during the past year.

Mr. Speaker, I move the adoption of this report.

The motion was seconded and carried that the report of the KSMA Pharmacy Committee be adopted.

Committee on Rural Health

This Committee has started work on one of the most important public relations projects ever given to organized medicine in Kentucky—the National Conference on Rural Health, which will be held in Louisville on March 7, 8, and 9, 1957. Mr. Aubrey Gates, Field Director of the AMA Council on Rural Health, will be working with KSMA and the Kentucky Rural Health Council in the promotion of this project. The Committee submitted three recommendations that it felt would help make this Conference a success.

Our Reference Committee feels that this Committee is to be commended for the work it has done and for its report in which the following recommendations were made:

"1. That the President of the KSMA for the year 1956-57 be directed to name one physician from each Councilor District to be responsible for the promotion of attendance at the 1957 National Conference for his Councilor District.

"2. That each physician appointed under No. 1 recommendation select one physician from each county in the Councilor District who will be responsible for the promotion of attendance from his home county.

"3. That the House of Delegates direct that the promotion of the Twelfth National Conference on Rural Health, which will be held at the Brown Hotel on March 7, 8, and 9, 1957, be recognized as of major importance to each member of the Kentucky State Medical Association."

After conference with the Chairman of this Committee, it is further recommended that the President of the Kentucky State Medical Association request of the President of the Jefferson County Medical Society that a Hospitality Committee be appointed to serve with the Committee on Rural Health.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Rural Health Committee be adopted.

Committee on School Health

It was the opinion of this committee that this is the opportune time for greater emphasis on direction of school health activities by the medical and dental professions, but there is still need for wider understanding of the problems by the individual physicians and dentists and a willingness on the part of county societies to cooperate. Such a state-wide program cannot be implemented in a hasty manner. The committee rcommends: (1) consultation with the State Dental Association, State Department of Public Instruction and State Department of Health regarding the formation of county school health committees; (2) an educational program directed at the profession regarding the school health problem by means of the Secretary's Letter and Journal; and (3) distribution of a copy of the approved principles of a school health program to each county medical society secretary with the request that they be read to the society.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the School Health Committee be adopted.

Advisory Committee on Physical Therapy

This committee had no activities of note to report.

Mr. Speaker, I move the adoption of this report.

The motion was seconded and carried that the report of the Advisory Committee on Physical Therapy be adopted.

Committee on Technical Exhibits

This committee reported that all available booths (65) were rented, and several companies were on the waiting list. It has endeavored to maintain the high standards of the exhibitors and carry on the campaign

to acquaint the membership with their products and services.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Committee on Technical Exhibits be adopted.

Conference of Presidents and Other Officers of Medical Associations

This conference was held on June 10 at Chicago. At this meeting KSMA's representative G. Y. Graves, M.D., was inducted as President. Doctor Graves submitted a resume of the program.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Conference of Presidents and Other Officers of Medical Associations be adopted.

Joint Commission for Improvement of Patient Care

This commission reported that it had discussed problems confronting hospitals, physicians, and nurses in relation to the patient. This Joint Commission continues to educate its members in the variety of problems that present themselves and serves a useful purpose in that impressions from various viewpoints are brought together.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of the Joint Commission for Improvement of Patient Care be adopted.

Advisory Council to the U. of L. School Student AMA Chapter

The KSMA representative on this Council reported favorably on the program and commended the fine work of Robert Overstreet, who was elected President of the Student AMA this past May.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of KSMA's Representative on the Advisory Council to U. of L. School Student AMA Chapter be adopted.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried that the report of Reference Committee No. 7 be adopted.

Signing the report of Reference Committee No. 7 were: L. F. Beasley, M.D., Franklin, chairman; Keith P. Smith, M.D., Corbin, vice-chairman; Carl Cooper, Jr., M.D., Bedford; Charles C. Rutledge, M.D., Hazard; J. S. Llewellyn, M.D., Louisville.

There was no unfinished business.

The Speaker requested that the nominees selected by the Awards Committee be presented again and that other nominations, if any, be made from the floor.

The nominees, as presented by the Awards Committee, were:

C. T. Coleman, M.D., for the General Practitioner Award

Joseph T. Molony, M.D., for the Distinguished Service Award

A motion was made, seconded and carried that the nominations be closed and that the Secretary cast a single ballot electing Doctors Coleman and Molony.

At this time the following were elected to fill the vacant offices for the coming year.

President Elect	Edward B. Mersch, M.D., Covington
Vice Presidents:	
Central	Karl D. Winter, M.D., Louisville
Eastern	Carl Norfleet, M.D., Somerset
Western	Charles R. Yancey, M.D., Hopkinsville
Secretary	Woodford B. Troutman, M.D., Louisville
Speaker	Clyde C. Sparks, M.D., Ashland
Vice Speaker	George W. Pedigo, Jr., M.D., Louisville
Delegate to AMA	W. Clark Bailey, M.D., Harlan
Alternate Delegate to AMA	Robert C. Long, M.D., Louisville

At this time the delegates from the counties in the districts which were to elect councilors and who had held individual meetings after the first session of the House presented their nominations and the following were elected:

First District	J. Vernon Pace, M.D., Paducah
Third District	Ralph D. Lynn, M.D., Elkton
Fourth District	W. Keith Crume, M.D., Bardstown
Eighth District	Norman Adair, M.D., Covington
(to fill unexpired term of Doctor Mersch)	
Twelfth District	Garnett J. Sweeney, M.D., Liberty
Fourteenth District	Charles C. Rutledge, M.D., Hazard

The Nominating Committee to serve at the 1957 Annual Meeting was elected as follows:

C. C. Johnston, M.D., Lexington
V. G. Kinnaird, M.D., Lancaster
John S. Llewellyn, M.D., Louisville
A. O. Miller, M.D., Louisville
Carlisle Morse, M.D., Louisville

The new Speaker announced that he would appoint the Awards Committee at a later date.

There being no further business a motion was made, seconded and carried that the meeting adjourn at 11:26 p.m.



EDITORIALS



"WHY"

FROM the earliest days of civilization, ever since man has attempted to resolve differences with his fellow man by wars, certain general strategic principles have been accepted as sound in pressing any military endeavor to a successful conclusion.

Among these is that a well-planned and well-executed offense is much more effective than even the best managed defense. An army capable of launching an offensive at a time and place of its own choosing, has a decided tactical advantage over its enemy who must wait with uncertainty until the battle is a reality, and, at that time, the deployment of his forces may not be commensurate with the striking power of his enemy.

In the ancient game of chess, the player who is able to take over the offensive, to deploy his knights, rooks, and pawns to strike at a time and place of his own design, is able to decimate gradually his opponents' forces while his adversary futilely jumps from space to space attempting to prevent a complete annihilation of his men. But as long as his opponent retains the offensive, the eventual weakening of his position will result in the inevitable check-mate.

Keeping this in mind, let us be introspective for a moment and evaluate medicine's position in the field of the medical care of our people. Certain fundamental questions present themselves demanding an answer. Why must private medicine be continually placed in the position of defending its very existence? Why are national lay groups taking over piece by piece certain diseases such as cancer, poliomyelitis, or cerebral palsy, etc., or certain phases of medical care, dictating its method of treatment, who shall or shall not care for the patient, what the care of the disease shall cost, or how much to remunerate the physician for dispensing his services?

Why is the government, through its various agencies, repeatedly and under numerous subterfuges, attempting to get ever increasing numbers of people out of the hands of private medicine and under the domain of a medical bureaucracy administered to a large extent by non-medical personnel who dictate an overall medical policy to the professional hirelings whom they employ? Why is private medicine gradually surrendering its prerogatives to sociologists of one type or another when these latter have already shown their ineffectiveness and their inability to keep abreast sociologically with the pace set by medicine in keeping larger and larger numbers of people alive and healthy over longer and longer periods of time?

A critical self-evaluation is mandatory NOW. Have we been guilty of allowing the softness of prosperous time or the comforts of present civilization to narcotize us into a blissful sense of complacency? Are we actually so self-centered that we have forgotten the needs of the people whom we are dedicated to serve? Have we entrenched ourselves in a fortress of smug indifference or behind a wall of vanity? Thus we have been accused by those attempting to usurp the prerogatives of private medicine. Or are the present members of the medical profession so spineless and lacking in the intestinal fortitude which characterized our professional forbears that we abjectly succumb to whatever and whomever desires to emasculate us and render us a completely negligible force in their overall plans.

Are we too weak or are we afraid to fight? Must we docilely submit to a not too gradual dismemberment until only a shell of what was once a virile profession remains? Or are we still capable of launching a powerful offensive?

Medicine is now definitely on the defensive. WHY?

Richard J. Rust, M.D.

HOW DEEP IS YOUR CONVICTION?

A House Committee of the United States Congress has recently mailed a questionnaire to most medical organizations relative to federal aid to medical education. The implications of this questionnaire are apparent to all of us.

As you know, the American Medical Education Foundation was organized and sponsored by the American Medical Association in 1951 to seek financial contributions in behalf of the medical schools. The medical profession's annual goal is $2,000,000 and this sum is needed in addition to funds contributed annually from other sources. Industry and business are asked

(Continued on Page 1091)

(Continued from Page 1090)

to assist in raising the additional amounts to meet the annual $10,000,000 operational deficit of our medical schools. Unless we reduce this deficit, the practice of medicine as we know it today will no longer exist.

In 1955 the A.M.E.F. disbursed $1,120,000 to the medical schools. Since 1951 the total forwarded by the Foundation has been $4,684,312. Together with contributions from industry collected through the National Fund for Medical Education $9,598,491 has been made available to the schools since 1951.

The fifth annual report of the Foundation shows that while approximately 20 per cent of Kentucky's physicians contributed to the alumni programs of their own schools, a substantially smaller percentage contributed to the A.M.E.F.

Unquestionably, the overwhelming majority of physicians will want to share in this vital program when they understand its full meaning. It may only be concluded from the statistics that most of our physicians have not been made aware of the pressing financial need that exists in our medical schools and need to be educated to the important role they as individuals must play in meeting the school's plight.

By contributing to the A.M.E.F. the medical profession is factually stating its depth of conviction in the present character of our medical schools. Additional solid response from our profession will stimulate a like response from business and industrial groups. Louis H. Bauer, M.D., A.M.E.F. President, points out, "As long as our institutions of higher learning remain free from Federal subsidy and control, the future freedom of this nation is assured and the rights of the individual protected."

Your KSMA Committee for Contributions to A.M.E.F. urges each member to recognize the opportunities and obligations that face us. Mail your contribution to the A.M.E.F., 535 North Dearborn St., Chicago 10, before January 1, 1957. You may designate the school you wish to have receive your contribution if you so desire.

Claude C. Waldrop, M.D., Chairman,
Committee for Contributions to A.M.E.F.

THE STAFF OF THE JOURNAL

of the

KENTUCKY STATE MEDICAL ASSOCIATION

WISHES YOU

A VERY MERRY CHRISTMAS

and a

HAPPY and PROSPEROUS NEW YEAR

GUY AUD, M.D.

Editor

ORGANIZATION SECTION

Rural Health Leaders Plan for National Conference

Approximately 25 state-wide organizations, interested in elevating rural health in the Commonwealth, are cooperating with the Kentucky Rural Health Council to promote attendance at the 1957 National Conference on Rural Health, to be held at the Brown Hotel in Louisville, March 7-9. The Conference is sponsored annually by the American Medical Association.

Activities are under the general direction of Wyatt Norvell, M.D., New Castle, chairman of the KSMA Committee on Rural Health and of the Kentucky Rural Health Council. Suggestions for program topics, entertainment, and special features, as received from the various groups, are being coordinated, and the annual nation-wide convention—coming to Kentucky for the first time—promises to be an outstanding one, according to Dr. Norvell.

Committees at the county level are handling local publicity and making arrangements for car-pools to the March meeting. Every county in the state has been asked to send at least two car loads of rural health supporters, stated Dr. Norvell.

AMA Clinical Meeting Held on West Coast in November

Some 2,000 physicians and 3,000 guests were expected to attend the annual Clinical Session of the AMA, held at Seattle November 27-30. This meeting was the 10th clinical session held by the AMA.

The "postgraduate education" meeting for the family doctor included four types of instruction: lectures and panels, closed circuit color television, motion pictures and exhibits with demonstrations.

Twelve clinic demonstrations and seven operations were televised directly from rooms in Doctors Hospital to Civic Auditorium, headquarters for the scientific sessions. Connecting cables ran from trucks parked outside the hospital to regular and surgical cameras in the surgery suite. A moderator, in direct contact with the hospital, passed along questions from the audience to physicians participating in the telecast.

Cincinnati Medical Academy 100 Years Old in February

The Academy of Medicine of Cincinnati will observe its 100th Anniversary with a week-long celebration, beginning February 27, at the Queen City's Music Hall.

There will be a 175-booth exhibition from the fields of science, research, medicine, health, community service, and the related areas of education, business and industry.

In addition to educational movies and lectures, there will be a health exhibit featuring "Juno," a transparent plastic depiction of the female body, on loan from the 1956 Dominican International Exposition.

Dr. McCarty Named Chairman of SMA Council

A. Clayton McCarty, M.D., Louisville, was elected chairman of the Council of the Southern Medical Association at the second general session of the Golden Anniversary Meeting in Washington on November 14.

J. P. Culpepper, Jr., M.D., Hattiesburg, was installed as SMA's 53rd president and W. Kelly West, M.D., Oklahoma City, was elected president-elect.

Sixty-seven Kentucky physicians attended the Anniversary Meeting during the three-day session, November 12-15, according to the SMA Daily Bulletin. They were:

Henry B. Asman, Oren A. Beatty, J. Randolph Buskirk, David M. Cox, John D. Gordinier, W. O. Johnson, Jesshill Love, A. Clayton McCarty, J. B. Marshall, William Ray Moore, Carlisle Morse, H. N. Ritter, Sam A. Overstreet, Gradie R. Rowntree, Richard R. Slucher, Silas H. Starr, Carroll L. Witten, Robert P. Bergner, Robert Lich, Glenn R. Powell, John J. Robbins, Oren L. Beatty, Walter S. Coe, W. M. Ewing, Charles E. Gaupin, Aurom M. Isaacs, Robert Liett, Jr., Robert W. Lykins, Robert F. Monroe, Alfred O. Miller, Oscar O. Miller, John Papas, James E. Ryan, and George C. Sivak, all of Louisville;

Rufus C. Alley, John B. Floyd, Jr., William K. Massie, Robert D. Shepard, J. A. Stoeckinger, George J. Gumbert, Wallace E. Herrell, W. N. Lipscomb, Maurice Kaufman, Learns R. Thompson, Lexington; John A. Bishop, Jeffersontown; E. E. DeVillez, Clifford N. Heisel, Howard R. Molony, James A. Ryan, Arthur J. Schwertman, Covington; W. H. Diessner, Middlesboro; William V. Eaton, Paducah; M. D. Flanary, Pikeville;

Charles C. Kissinger, D. L. Vaughn, Henderson; Max D. Klein, L. A. Wahle, Shelbyville; Ralph D. Lynn, Elkton; W. P. McKee, W. H. Rush, Frankfort; Robert J. Salisbury, Mt. Sterling; A. D. Steely, Bardstown; R. G. Townsend, Grayson; Charles A. Wood, Auburn; Paul F. Maddox, Campton; Walter F. Williams, Ashland; Shelby Carr, Richmond.

Approximately 3000 physicians registered for the three-day meet.

Dr. Adams Represents KSMA at Civil Defense Meet in Chicago

Theodore L. Adams, M.D., Lexington, chairman of the Committee on Emergency Medical Service, represented the KSMA at the seventh County Medical Societies Civil Defense Organization conference in Chicago on November 10-11.

The conference was sponsored by the American Medical Association's Council on National Defense, and was designed to help local medical personnel plan their work in case of an emergency.

A conference symposium was devoted to the problems of psychological disorders and their effect in large scale civilian disaster and defense.

Dr. Hancock Heads Blue Shield



Dr. Hancock

J. Duffy Hancock, M.D., Louisville, KSMA president in 1954-55, has been elected president of the Kentucky Physicians Mutual, Inc., which is the Blue Shield plan for Kentucky.

Re-elected first and second vice-presidents were Coleman C. Johnston, M.D., Lexington, and William H. Cartmell, M. D., Maysville, Branham B. Baugham, M.D., Frankfort, was re-named treasurer. J. P. Sanford, Louisville, executive secretary of KSMA will serve as secretary of the Physicians Mutual. Stanley T. Simmons, M.D., Louisville, will serve as medical advisor. D. Lane Tyne, Louisville, is the executive director and Robert L. Dean, Louisville, was named assistant treasurer.

New Council is Governing Body of 4,000 Med. School Alumni

The 20-man Advisory Council of the Alumni Association of the U of L School of Medicine held its first meeting November 1, according to Leslie Shively, director, alumni relations.

Six representatives from Jefferson County and one from each Councilor District in Kentucky make up the Council, the governing body of the 4,000 medical school alumni. Officers are: Karl Winter, M.D., Louisville, chairman; Maurice Kaufman, M.D., Lexington, vice-chairman; and George McAuliffe, M.D., Louisville, secretary.

Projects for the coming year are: (1) initiation of a postgraduate education program, (2) an expanded news bulletin, (3) establishment of an Alumni Day during the KSMA Annual Meeting, (4) selection of an "Alumnus of the Year," (5) meetings for the medical alumni throughout the state.

The Advisory Committee includes: Dist. 1, Robert Robertson, M.D.; Dist. 2, F. Hayes Threlkel, M.D.; Dist. 3, Gaithel Simpson, M.D.; Dist. 4, Keith Crume, M.D.; Dist. 5, Charles Bryant, M.D., Max Jones, M.D., Sam Clark, M.D., D. P. Hall, M.D., George McAuliffe, M.D., and Karl Winter, M.D.; Dist. 6, C. C. Howard, M.D.; Dist. 7, Joe Liebman, M.D.; Dist. 8, Vinson Pierce, M.D.; Dist. 9, Joe McKinney, M.D.; Dist. 10, Maurice Kaufman M.D.; Dist. 11, Joe Bush, M.D.; Dist. 12, Garnett Sweeney, M.D.; Dist. 13, Clyde Sparks, M.D.; Dist. 14, Ballard Cassaday, M.D.; Dist. 15, Keith Smith, M.D.

Increase in Nurses Still Does Not Satisfy Demand

An increase in the employment of professional nurses from 401,600 in 1954 to 430,000 in 1956 has failed to meet the demand for service, according to the American Nurses' Association.

The need for more and more nurses has been brought about by advances in medical sciences, prepayment insurance plans, hospital construction and the awareness of better health possibilities on the part of the general public.

The present allocation of nurses, the ANA reports, is as follows: hospital and related institutions, 265,800; private duty, 72,000; office nurses, 36,000; public health, 27,200; industry 17,000; nursing education, 10,400; other fields, 1,600. The increase from 1954 has been rather evenly distributed among all the groups shown, the report discloses.

Doctors' Aides Organize at Milwaukee Meeting

Some 250 employees in physicians' offices from 16 states met recently at Milwaukee and formed a national organization known as the American Association of Medical Assistants.

The group included nurses, secretaries, technicians, receptionists and the combination "Girl Friday" to busy doctors. They were from states where local groups had organized for the purpose of "inspiring members to render honest, loyal and more efficient service to the profession and the public, to strive with the profession in improving public relations and to render additional service for the self-improvement to the members."

The organization is non-profit and its members are pledged never to "become a trade union or a collective bargaining agency," according to George F. Lull, M.D., secretary-general manager of the AMA.

Sixth Councilor District Presents TB Panel

John H. Gross, M.D., senior staff physician of the Battey Hospital of Rome, Georgia, was scheduled to speak at the Sixth Councilor District meeting at Glasgow on December 5.

A panel on "Diseases of the Chest," moderated by Clifton G. Follis, M.D., Glasgow, listed the following participants: R. F. Grise, M.D., Bowling Green, E. S. Dunham, M.D., Edmonton, Nathan Lavene, M.D., Louisville, John H. Gross, M.D., Rome, Ga., W. S. Burton, M.D., Glasgow, E. F. Puess, M.D., Glasgow.

Doctor-Lawyer Relations to Be Shown in New Film

"The Medical Witness," a film premiered Nov. 27, at the AMA interim meeting in Seattle re-enacts the trial of a personal injury case, and unites the forces of the American Medical Association with the American Bar Association in a service to both.

Doctors and lawyers are shown how to develop expert testimony in the best interest of the plaintiff, the judge and the jury. It provides medical societies and bar associations with answers to questions arising from the practice of presenting medical evidence through partisan experts hired by parties to law suits.

Medical societies wishing to arrange for showings of "The Medical Witness" may write to the Film Library, American Medical Association, 535 North Dearborn St., Chicago 10, Ill.

Eleventh Councilor District Holds Meeting at Berea

Richard R. Slucher, M.D., Louisville, KSMA president, spoke at the annual dinner meeting of the Eleventh Councilor District at Boone Tavern in Berea on November 8. His subject: "Why Belong to the KSMA?"

Arthur Keeney, M.D., instructor of ophthalmology at the University of Louisville School of Medicine, presented the evening's scientific lecture. He discussed "The Bloody Eye."

Approximately 55 physicians and their wives attended the meeting, according to Hugh Mahaffey, M.D., Richmond, Eleventh District Councilor.

State Hospital Head Retires

Richard S. Ahrens, M.D., will retire in December as superintendent of Kentucky State Hospital, Danville, due to ill health, according to an announcement by Frank M. Gaines, M.D., State mental-health commissioner. Dr. Ahrens was on the faculty of the University of Minnesota many years before coming to Kentucky in 1947 as clinical director at the Danville hospital. No successor has been named.

Dr. Coleman Appears on TV

C. T. Coleman, M.D., named the Outstanding Practitioner of the Year by the House of Delegates of the KSMA in September, recently appeared on a Louisville television program.

Dr. Coleman was interviewed relative to his medical practice and civic projects at Frankfort as a guest of Phyllis Knight on "Small Talk."

Symposium Held in Lexington

A two-day symposium, sponsored by the Lexington Clinic, was held at the Lafayette Hotel in Lexington on October 12-13.

Approximately 150 physicians from Central and Eastern Kentucky attended the meeting and heard the scientific papers presented.

Gen. Burney Named to NRS

Leroy Burney, M.D., Surgeon General of the U. S. Public Health Service, has been appointed to the Advisory Board of the National Resuscitation Society, Inc.

The Society will present a course in Clinical Hypoxia on December 7-8, open to physicians and dentists. Attention will be focused on didactic and clinical material (lectures, demonstrations, dog work, anesthetized patients and cadaver practice) to acquaint the student with the death zone of the respiratory tract.

Educator is Research Advisor

J. Murray Kinsman, M.D., F.A.C.P., Dean, School of Medicine, University of Louisville, has accepted membership in the advisory committee of the National Disease and Therapeutic Index medical statistical research program, it has been announced.

The Index is designed to provide continuous statistical information for study of the reasons why patients see doctors and the types of treatment they receive. Nine hundred doctors in 27 representative areas are each making a full report of all patients seen during a consecutive two-day period once each quarter.

Cancer Unit Aids Speech Program

Financial support for an esophageal speech program for laryngectomized persons will be provided by the Kentucky Division of the American Cancer Society, according to James N. Burrows, administrator of the Rehabilitation Center, Louisville.

An instructor who has been using esophageal speech since undergoing a laryngectomy has been employed to take charge of the program. His work will be supervised by a certified speech therapist. The program will be conducted at the Rehabilitation Center, 340 East Madison, Louisville, as another service to physicians.

Call KSMA at JUniper 5-5815

The new telephone number for the Kentucky State Medical Association's Headquarters office in Louisville is JUniper 5-5815. It became effective at Midnight, November 17.

STUDENT AMA

It was my pleasure and privilege to be the student representative from the University of Louisville to the Golden Anniversary Meeting of the Southern Medical Association, held in Washington, D.C., November 10-15. I would like to use this month's column to express the pleasure it was for me to make this expense-paid trip, and to cite for you the opportunities that became available to me while in Washington.

The medical schools represented at this meeting were:

Bowman Gray; Duke University; Georgetown University; George Washington University; Johns Hopkins University; University of Louisville; University of Maryland; University of North Carolina; University of Virginia; Medical College of Virginia.

The students assembled in Washington at noon on Saturday, November 10, for luncheon, registration, and getting acquainted. We then met with the Council of the S.M.A. and found out that the idea of student representatives is being tried for the first time this year and will be continued if it is considered successful.

The group was given box seats to the Washington Redskins professional football game on Sunday.

The meeting officially opened on Monday and we were allowed to attend the scientific sessions of our choice. There were cocktails and dinner in our honor Monday evening and a number of brief talks. These interesting and certainly timely remarks included: "The Physician and the AMA," George F. Lull, M.D., Secretary and General Manager, AMA, Chicago; "The Physician and His State Medical Society," Joseph P. Sanford, Executive Secretary, KSMA, Louisville; "The Physician and His Local Medical Society," Steve Yates, Executive Secretary, Jefferson County Medical Society, Birmingham; "The Medical Student and the Student American Medical Association," Russell F. Staudacher, Executive Secretary, SAMA, Chicago; "So You Want to Publish a Paper?" R. H. Kampmeier, M.D., Editor SMA Journal and the Journal of Tennessee State Medical Association, Nashville; "Where Does the Southern Medical Association Come In?" A. Clayton McCarty, M.D., Vice-chairman, SMA Council, and Councilor for Kentucky, Louisville.

The first General Session was held that night, at which time we were officially introduced. We then heard an address "Fifty Years of Progress" by W. Raymond McKenzie, M.D., president of the SMA. Tuesday was not officially scheduled in order to give the students a chance to attend more sessions and to visit the technical and scientific exhibits. Outstanding papers were presented in 20 sections.

Wednesday was "Education Day" for section meetings and exhibits. The second General Session was Wednesday night. David B. Allman, M.D., president-elect of the A.M.A., impressed upon us the democratic opportunities and values of organized medicine in his talk, "Who Will Carry the Torch?"

On Thursday the group had luncheon with the officers and staff of the S.M.A. at which time we had the opportunity to express our gratitude for the trip and to hear their evaluation of the success of the meeting. The practice of inviting senior medical students is to be continued in the future.

The students were given a one-year complimentary subscription to the Journal of the S.M.A., in which we can read many of the talks that we heard and some of those on sessions we were unable to attend.

The entire meeting impressed us with the enthusiastic spirit of the Southern, the progress of medicine through the Southern, and the absolute value of organized medicine in the form of associations such as the Southern.

Robert G. Overstreet, President
U. Of L. Chapter, Student AMA

FOR POSITIVE DIURESIS

ROLICTON*

- oral b.i.d. dosage
- continuous control of edema

The new, highly effective oral diuretic, Rolicton, greatly simplifies the task of maintaining an edema-free state in the patient with congestive heart failure. Rolicton meets the criteria for a dependable diuretic: continuous effectiveness, oral administration and clinical safety.

In extensive clinical studies the diuretic response clearly indicates that a majority of patients can be kept edema-free with Rolicton. In these investigations it was noted that side reactions were uncommon. When they did occur they were usually mild.

In most edematous patients Rolicton may be employed as the sole diuretic agent. When used adjunctively in severe cases, Rolicton is also valuable in eliminating the "peaks and valleys" associated with the parenteral administration of mercurial diuretics.

One tablet of Rolicton b.i.d., after meals, is usually adequate for maintenance therapy after the first day's dosage of four tablets. Some patients respond well to one tablet daily. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.



*Trademark of G. D. Searle & Co.

SEARLE

Gov. Names Jane Crawford Day

December 13 has been proclaimed as Jane Todd Crawford Day by Governor A. B. Chandler, in honor of the woman who submitted to the first ovarian tumor operation in Kentucky. The operation was performed by Ephriam McDowell, M.D., called the father of ovariotomy. The McDowell House at Danville has been made a shrine, commemorated to the historical operation.

UK Dean Joins Indigent Unit

Dean William R. Willard, M.D., of the University of Kentucky Medical School, Lexington, has been appointed to serve on the commission on indigent care by Governor A. B. Chandler. Previously named to the commission were KSMA members Gaithel Simpson, M.D., Greenville, and Thomas P. Leonard, M.D., Frankfort. Keith P. Smith, M.D., Corbin and Russell Teague, M.D., Louisville. Dr. Teague is chairman of the commission.

Dr. Humpert is TB Chairman

Joseph H. Humpert, M.D., Covington, has been named chairman of the Kentucky State Coordinating Council for the Control of Tuberculosis. Other officers include Donald P. Conwell, M.D., director of the bureau of preventive medicine of the State Department of Health, vice-chairman, and Joe D. Miller, executive director of the State TB Hospital Commission, secretary.

Two members from each of seven allied organizations comprise the council. Representatives of the Kentucky Hospital Association, the Kentucky Board of Nursing Education and Registration, and the Kentucky State Association of Registered Nurses have recently been added to the membership.

Dr. Overstreet Named to ACG Post

Sam A. Overstreet, M.D., Louisville, was elected a governor of the American College of Gastroenterology at its recent annual meeting in New York. Dr. Overstreet was graduated from the U of L Medical Department in 1923 and served as the KSMA Centennial Year president.

Dr. Steigman is Honored

Alex J. Steigman, M.D., Louisville, was recently awarded the honorary degree of doctor of science by his alma mater, Temple University, at Philadelphia. The award was made in recognition of his study, research and discoveries in child-health problems.

Dr. Steigman is professor of child health at the U. of L. School of Medicine, head of the department of pediatrics, and director of the Child Health Foundation's virus laboratory at the U. of L. His work has included the uncovery of two viruses which cause symptoms like polio.



Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

C I B A
Summit, N. J.

2/22261

MONODRAL® WITH MEBARAL®



ANTICHOLINERGIC • SEDATIVE

in peptic ulcer management

- relieves pain promptly
- reduces tension safely
- tranquilizes without dulling
- well tolerated
- promotes healing
- maintains anacidity for hours
- controls hyperactivity of upper gastro-intestinal tract

MONODRAL with MEBARAL—the "psychovisceral stabilizer"—provides for patients with ulcer and gastro-intestinal spasm an effective barrier against the impact of environmental stimuli . . . controls gastric hypersecretion and hypermotility for three and one half to five hours.*

EACH TABLET CONTAINS:
MONODRAL bromide..... 5 mg.
MEBARAL.....32 mg.

DOSAGE: 1 or 2 tablets three or four times daily.
Available on prescription only.
Bottles of 100 tablets.

Winthrop Laboratories New York 18, N. Y.

Monodral (brand of penthienate) and Mebaral (brand of mephobarbital), trademarks reg. U. S. Pat. Off.
*References and clinical trial supplies available on request.

Heads Outpatient Service

Hobart D. Belknap, M.D., a retired Army colonel, has been named chief of the emergency room at Louisville's General Hospital, and director of its outpatient services. He will also direct a Medical Education for National Defense program at the University of Louisville starting January 1.

A veteran of three wars, including service around the world, Dr. Belknap was retired this fall due to age, while commanding the 34th General Hospital in Orleans, France.

Four MDs Promoted at U of L

Recent promotions at the U. of L. School of Medicine include: Armand E. Cohen, M.D. to associate professor of medicine; Alphonso Guiglia, M.D. to associate professor of psychiatry; L. Douglas Atherton, M.D. to instructor in urology; and Wynant Dean, M.D., to instructor in ophthalmology.

News Items

Noble T. McFarlane, Jr., M.D., a pediatrician, began his duties on the staff of the Lexington Clinic in October. Dr. McFarlane received his medical degree from the University of Virginia School of Medicine in 1953. He interned at Virginia Mason Hospital, Seattle and completed a residency at the St. Louis, Mo., Children's Hospital in June.

A. M. McKeithen, M.D., a Louisville surgeon for many years, has moved to Cameron, N. C.

Patricia K. Conlan, M.D., Louisville, has been appointed health officer for the Hardin County Health Department. She is a graduate of the U. of L. School of Medicine in the Class of 1952.

E. H. Miller, M.D., and Mrs. Miller, Vine Grove, celebrated their 50th wedding anniversary on October 20. A veteran of World Wars I and II, Dr. Miller completed, on September 1, his 50th year of practicing medicine.

E. J. Yelton, M.D., and Mrs. Yelton, Germantown, were recently honored on their golden wedding anniversary at a reception attended by more than two hundred well-wishers. Dr. Yelton was graduated from the U. of L. Medical Department in 1907.

John L. Housley, M.D., has begun a practice at Berry, in Harrison County. A native of Akron, Ohio, and a graduate of New York Homeopathic Medical College in 1931, Dr. Housley came to Harrison from Lee County. He had served as a medical missionary in the home mission field.

Edward Perraut, a graduate of the U. of L. School of Medicine in 1946, has resumed his practice of medicine at London following his return from military service.

Council Appointed Committees 1956 - 1957

Committee on Medical Education and Economics

Gaithel Simpson, M.D., Greenville, Chairman
A. B. Barrett, M.D., Lexington
Morris M. Garrett, M.D., Covington
Robertson O. Joplin, M.D., Louisville
Claude C. Waldrop, M.D., Williamstown

Associate Committee on Insurance

A. B. Barrett, M.D., Lexington, Chairman
Lillard F. Beasley, M.D., Franklin
Auldin J. Bishop, M.D., Jeffersontown
Arthur L. Cooper, M.D., Somerset
Robert E. Reichert, M.D., Covington

Associate Advisory Committee to the University of Louisville School of Medicine

Robert O. Joplin, M.D., Louisville, Chairman
John G. Archer, M.D., Prestonsburg
Mitchell B. Denham, M.D., Maysville
C. C. Howard, M.D., Glasgow
John S. Quertermous, M.D., Murray

Associate Committee on Veterans

Morris M. Garrett, M.D., Covington, Chairman
B. Earl Caywood, M.D., Danville
Thomas J. Crume, M.D., Owensboro
John Dickinson, M.D., Glasgow
Wendell V. Lyon, M.D., Ashland

Associate Committee for Contribution to the American Medical Education Foundation

Claude C. Waldrop, M.D., Williamstown
J. Gant Gaither, M.D., Hopkinsville
Delou P. Hall, M.D. Louisville
Paul B. Hall, M.D., Paintsville
Coleman C. Johnston, M.D., Lexington

Medico-Legal Administrotor

John D. Gordinier M.D., Louisville

Advisory Committee to the Editor

Richard J. Rust, M.D., Newport, Chairman
James E. Hix, M.D., Owensboro
Francis M. Massie, M.D., Lexington

Committee on Public Informotion and Service

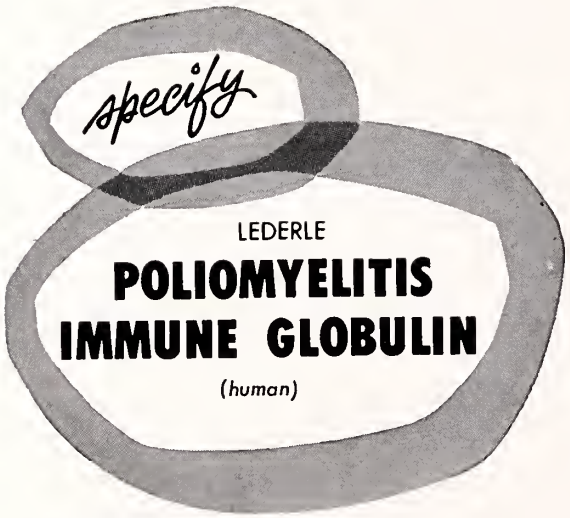
Richard G. Elliott, M.D., Lexington, Chairman
Joe M. Bush, M.D., Mt. Sterling
Carl Cooper, Jr., M.D., Bedford
George W. Pedigo, M.D., Louisville
Robert W. Robertson, M.D., Paducah

Committee on Physicions Plocement Service

Delmas M. Clardy, M.D., Hopkinsville, Chairman
N. L. Bosworth, M.D., Lexington
Joe M. Bush, M.D., Mt. Sterling
Walter S. Coe, M.D., Louisville
Julian B. Cole, M.D., Henderson
Russell H. Davis, M.D., Pikeville

OFFICE SPACE

Ideal location, professional building, convenient to all forms of transportation; near all hospitals; air conditioning, parking facilities about 600 sq. ft.; alterations to suit tenant. Contact Mr. Morgan Goodpaster, Security Trust Company, Lexington, Kentucky.



Lederle

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY Pearl River, New York

PATENTED WEDGE GIVES SUPPORT TO CENTER LINE OF BODY WEIGHT ★



★ Insole extension and wedge at inner corner of heel where support is most needed.

- The potented orch support construction is guoronteed not to breok down.
- Innersoles guoronteed not to crock or collopse.
- Foot-so-Port losts designed ond the shoe construction engineered with orthopedic odvice.
- Conductive Shoes for surgicol ond operoting room personnel. N.B.F.U. specificotions.
- We ore olso the monufocturer of the Geor-Action Shoe designed by noted orthopedic surgeon.
- We moke more shoes for polio, club feet ond disobled feet thon ony other shoe monufocturer.

Send for free booklet, "The Preservotion of the Function of the Foot Boloncing ond Synchronizing the Shoe with the Foot."

Write for details or contoct your locol **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.
A Division of Musebeck Shoe Company

PERTINENT PARAGRAPHS

Postgraduate courses on Diseases of the Chest will be presented by the Council on Postgraduate Medical Education of the American College of Chest Physicians as follows: Vanderbilt University, Nashville, January 14-18; Mark Hopkins Hotel, San Francisco, February 25-March 1; Bellevue-Stratford Hotel, Philadelphia, April 1-5. Tuition for each course is $75. For further information write to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Ill.

The United Brotherhood of Carpenters and Joiners, one of the labor organizations that joined the medical profession in fighting national compulsory health insurance during the Truman administration, celebrated its 75th anniversary in Washington recently. Representatives present from the American Medical Association heard President Eisenhower refute charges that his administration was dedicated to furthering the interest of 'big business.' "

Announcement has been made of the estoblishment of the National Medical Foundation for Eye Care, a non-profit scientific and educational institution. It was organized by ophthalmologists to present to the public generally and to fellow physicians information on the care and treatment of the eyes.

High School students winning awards ot the National Science Fair at Los Angeles in May will be guest exhibitors at the AMA's Annual Meeting June 3-7 in New York City. Awards are being made to high school students to encourage scientifically-talented youth to enter the study of medicine. The contests include exhibits in basic medical science.

Internists, generol proctitioners and pediotricions will be interested in four courses being offered in January 1957 by the New York University Post-Graduate Medical School. The courses deal with heart diseases, clinical internal medicine, a seminar in dermatology and syphilology, and a pediatrics refresher course.

In Memoriam

T. ACHESON FRAZER
Marion
1870-1956

Dr. Frazer, 86, who in 1942 was named Kentucky's first Rural Doctor of the Year, died October 23 at the Crittenden County Hospital.

One of Marion's "most beloved citizens," Dr. Frazer founded the hospital in which he died, was instrumental in establishing his county's local health department and founded the Kentucky Crippled Children's Society. He had served as president of the Kentucky Ornithological Society.

A graduate of the Vanderbilt Medical School in 1893, Dr. Frazer had been a practicing physician in Webster and Crittenden counties for 63 years prior to his retirement in 1955.

W. H. WHEELER
Olive Hill
1878-1956

Dr. Wheeler, 79, an Eastern Kentucky physician for 56 years, died of a heart attack at Ashland on October 15.

In 1950 Dr. Wheeler received the Stovall Award as the Outstanding Physician in Kentucky and in 1951 the 50 year Award of Merit of the American Medical Association.

He was a graduate of the Tennessee Medical College in 1901 and practiced at Charley, West Liberty and Ashland before going to Olive Hill.

COLUMBUS MARION THOMPSON
Kings Mountain
1865-1956

The oldest physician of Lincoln County, Dr. Thompson died at his home at Kings Mountain on November 1 at the age of 91. He had delivered more than 3,800 babies during the 63 years of his practice.

Dr. Thompson was a graduate of the old Eclectic Medical College of Cincinnati, in 1891. He began his practice in Pulaski County the same year and moved to Lincoln County two years later.

JAMES LOUIS VALLANDINGHAM
Lexington
1923-1956

Dr. Vallandingham, 32, died at the home of his mother in Lexington on October 20.

He was graduated from the U. of L. School of Medicine in 1946 and recently re-established practice in Lexington after serving in the armed forces.

JUDSON D. BELTON
Louisville
1896-1956

Dr. Belton, 58, died at SS Mary and Elizabeth Hospital on October 31. A native of Cincinnati, he had practiced in Louisville 30 years.

He was graduated from the U. of L. School of Medicine in 1923 and had served in the Medical Corps during World War I.

C. H. BYRD
Harrodsburg
1893-1956

A retired physician since 1954, Dr. Byrd, 65, died of a heart attack on October 29 at his home in Harrodsburg.

He was graduated from the U. of L. School of Medicine in 1933 and had practiced medicine in Durham, N. C., and in Pike County and Lebanon for a total of 31 years before his retirement.

1956 CONSTITUTION AND BY-LAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

Revised September 19, 1956

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition of the Association
Article V. House of Delegates
Article VI. Sections and District Societies
Article VII. Sessions and Meetings
Article VIII. Officers
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Meaning of Term "County Societies"

BY-LAWS

Chapter I. Membership
Chapter II. Annual and Special Sessions of the Association
Chapter III. General Meeting
Chapter IV. House of Delegates
Chapter V. Election of Officers
Chapter VI. Duties of Officers
Chapter VII. The Council
Chapter VIII. Committees
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI. Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

CONSTITUTION

Article I. Name of the Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge, and the advancement of medical science and charity, to the elevation of the standard of medical education and to the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and to the guarding and fostering of their material interest; to protect the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problem of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition of the Association

The Association shall consist of the members of the component societies and the House of Delegates shall have authority to adopt By-laws regulating the admission and classification of members as deemed advisable.

Article V. House of Delegates

Section 1. The House of Delegates shall be the legislative and business body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session to adopt by-laws to carry out the provisions of this Constitution.

Section 2. Delegates shall be members of and elected by component societies in accordance with the by-laws. Officers of the Association and delegates to the American Medical Association and the five immediate past-presidents shall be ex-officio members of the House of Delegates and entitled to vote.

Section 3. The speaker or vice-speaker shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie vote.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VI. Sections and District Societies

The House of Delegates may provide a division of the scientific work of the Association into appropriate Sections and for the organization of such Councilor District Societies as will promote the best interest of the profession, such societies to be composed exclusively of members of component societies.

Article VII. Sessions and Meetings

The Association shall hold an annual session and such special sessions as may be desirable in accordance with the by-laws of the Association.

Article VIII. Officers

Section 1. The Officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, and a Councilor from each Councilor District that may be established and such other officers as provided for in the by-laws.

Section 2. The officers of the Association shall serve for the term of office and subject to provisions as specified in the by-laws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. The Officers of the Association shall be elected by the House of Delegates at the annual session of the Association and shall take office on the last day of the annual meeting.

Article IX. Funds and Expenses

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by an equal per capita assessment upon each county (component) society to be fixed by the House of Delegates by voluntary contribution and from other sources of revenue. Funds may be appropriated by the House of Delegates to defray the expenses of the Annual Session, for publication and for such other purposes as will promote the welfare of the Association and profession.

Article X. Referendum

The General Meeting of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a similar vote of its own members or after a like vote of the General Meeting, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question and be binding upon the House of Delegates.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Annual Session, provided that such

amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Meaning of Term "County Societies"

Anywhere in the Constitution, Articles of Incorporation, or by-laws in which the term county society, or county societies, component county society or component medical society appears, it shall be construed to mean component society.

BY-LAWS

Chapter I. Membership

Section 1. A member of this Association must be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association the name of the member shall be included in the official roster of the Association and the member shall be entitled to all the privileges of his class membership.

Section 2. Active Members. Active members shall comprise the active members of the component medical societies. To be eligible for active membership in any component county society the applicant must be:

A. A doctor of medicine who is licensed to practice medicine in the State of Kentucky and who is of good moral and professional standing.

B. A medical officer of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

C. Any doctor of medicine engaged in scientific or professional pursuits whose principles and ethics are consonant with those of the State Association.

Section 3. Associate Members. Associate members shall consist of associate members of the component medical societies who are not eligible for active membership and who are qualified under one or more of the following groups:

A. An intern, resident or teaching fellow who is a Doctor of Medicine but who is not licensed to practice medicine in the state.

B. A person who is not a Doctor of Medicine but who is engaged in scientific, professional or other pursuits, whose principles and ethics are consonant with those of the Association.

C. A Doctor of Medicine residing and practicing outside the area covered by the component society and who is an active member in good standing in his own component society.

Associate members shall not have the right to vote nor to hold office. The Council shall, from time to time, determine the amount of dues to be charged. Associate members shall receive The Journal and the publications of the Association.

Section 4. Emeritus Members. Component societies may elect as a Member-Emeritus any Doctor of Medicine who has retired from active practice and who has previously maintained active membership in good standing in his own society. Emeritus members shall not have the right to vote nor to hold office and shall not pay dues. They shall receive The Journal and other publications of the Association.

Section 5. Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The Council shall determine, from time to time, the amount of dues to be charged. Student members shall receive The Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

Section 6. Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent State Medical Association and who has participated in the program of the Scientific Session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privilege on the floor in all scientific sessions.

Section 7. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any annual session upon invitation of the Association or its Council and shall be accorded the privilege of participating in all of the scientific work of that session.

Section 8. The name of a physician upon the properly certified roster of members or list of delegates, of a chartered county society which has paid its annual assessment, shall be prima facie evidence of his right to register at the Annual Session in the respective bodies of this Association.

Section 9. No persons who are under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its rolls of membership, shall be entitled to any of the rights or benefits of this association or its proceedings until such time as he has been relieved of such liability.

Section 10. Each member in attendance at the Annual Session shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member or delegate shall take part in any of the proceedings of an annual session until he has complied with the provision of this section.

Chapter II. Annual and Special Sessions of The Association

The Association shall hold an annual session and such special session at such times and places as may be determined by the House of Delegates. All sessions shall be limited to the scientific, educational, legislative, economic and business activities of the Association. Such special sessions shall be held in accordance with the provisions of Chapter IV, Section I of the by-laws.

Chapter III. General Meeting

The General Meeting shall include all registered active members, associate members and guests. Associate members and guests shall not have the right to vote on pending questions, but shall have equal rights with active members to participate in the proceedings and discussions. Each General Meeting shall be presided over by the President or in his absence or disability or upon his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the entire time of the sessions as far as may be, shall be devoted to papers and discussions relating to scientific medicine.

Chapter IV. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Session of the Association and shall so fix its hours of meeting as not to conflict with the first General Meeting of the Association, or with the meeting held for the address of the President so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interest of the association and profession require, it may meet in advance or remain in session after the final adjournment of the

General Meeting. The House of Delegates may be called into special session by the President with the approval of the Council and a special session of the House of Delegates shall be called by the President on a written request of the delegates representing fifty or more component county societies. When such special session is called, the Secretary shall mail a notice of the time and place and purpose of such meeting to the last known address of each member of the House of Delegates at least ten days before such special session.

Section 2. In the event there is no duly authorized delegate in attendance at the regular meeting of the House of Delegates the President shall consult any duly elected officer of the component society who is in attendance and with the approval of the Credentials Committee may appoint any active member of the component society in attendance at the meeting as the delegate. In the event there is no duly elected officer of the component society in attendance, the President may make the said appointment with the approval of the Credentials Committee. All appointments made shall also be with the approval of the House of Delegates.

Section 3. A majority of the registered delegates shall consitute a quorum and all of the meetings of the House of Delegates shall be open to members of the Association. The House of Delegates shall have the right to go into executive session whenever such action is indicated in the judgment of the House of Delegates, except that active members of the Association shall have the right to attend all executive sessions.

Section 4. Each resolution introduced into the House of Delegates shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 5. No new business shall be introduced in the last meeting of the House of Delegates without unanimous consent of the Delegates except when presented by the Council. All new business so presented shall require three-fourths affirmative vote for adoption.

Section 6. It shall, through its officers, Advisory Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Session a stepping stone to further ones of higher interest.

Section 7. It shall consider and advise as to material interest of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.

Section 8. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who can be made reputable, has been brought under medical society influence.

Section 9. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 10. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

Section 11. It shall upon application provide and issue charters to county societies organized to conform to the spirit of the Constitution and By-Laws.

Section 12. In sparsely settled sections two or more County Societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The County Society thus combined shall not lose any of its privileges and representation. The active members of each County Society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the State Association.

Section 13. The state shall be divided into the following councilor districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Spencer, Taylor and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby and Trimble.

No. 8—Boone, Campbell and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott and Robertson.

No. 10—Fayette, Jessamine and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie and Whitley.

Councilor district meetings may be held as desired, and District Medical Associations may be organized as desired according to the districts outlined above.

Section 14. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 15. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 16. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

Chapter V. Election of Officers

Section 1. The President-Elect and the Vice-Presidents shall be elected for a term of one year. The Speaker and Vice-Speaker of the House of Delegates shall be elected for a term of three years. The Secre-

tary and Treasurer shall be elected for a term of five years. The Councilors shall be elected for a term of three years and shall be limited to serving for not more than two consecutive terms. The terms shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice-President, Speaker or Vice-Speaker of the House of Delegates, or Councilor who has not been an active member of the Association for at least five years.

Section 2. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting continue until an election occurs in like manner.

Section 3. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of this Association shall be ineligible for any office for two years.

Section 4. The election of officers shall be held during the closing session at the regular annual meeting of the House of Delegates.

Section 5. During the last session of the House of Delegates the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the County Society Officers' Conference, or at some other appropriate place designated by the Council at least four months before the Annual Meeting. The Committee, in addition to such other sessions as it may choose to hold, will schedule an open meeting immediately after the close of the first session of the House of Delegates at each Annual Meeting. This open session shall be held in the same meeting hall, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Following this meeting, the Committee shall announce its final recommendations at the beginning of the second scientific session the following day, the Committee submitting one or more names for each officer to be elected. The House of Delegates will vote on the nominees at its second session. Additional nominations may be made from the floor by submitting the nominations without discussion or comment.

Section 6. The Delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating a Councilor for the Councilor District concerned. This committee shall hold a meeting open to all active members of Councilor District concerned who are in attendance at the meeting for the purpose of discussing the nomination for the Councilor to serve the District. Additional nominations may be made from the floor by any member of the House of Delegates when the Nominating Committee makes its report to the House of Delegates.

Chapter VI. Duties of Officers

Section 1. The President shall preside at all general meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Councilors in building up the county societies and in making their work more practical and useful.

Section 2. The President-Elect shall be a member of the Committee on Scientific Assembly. He shall become President of the Association at the next annual meeting of the Scientific Session following his election as President-Elect. He shall assist the President in visitation of county and other meetings and shall be ex-officio a member of the House of Delegates with the right to vote. In event of death, resignation, or if he becomes permanently disqualified, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at the next annual meeting of the Scientific Session of the Association.

Section 3. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation or removal, the Council shall elect one of the Vice-Presidents to succeed him.

Section 4. The Speaker of the House of Delegates of the Association shall preside at all meetings of the House of Delegates. He shall appoint all commitees for the House of Delegates with the approval of the House of Delegates. He shall be an ex-officio member of all said committees. He shall perform such other duties as custom and parliamentary usage may require.

Section 5. The Vice-Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, resignation or removal of the Speaker, the Vice-Speaker shall automatically become Speaker of the House of Delegates.

Section 6. The Treasurer shall demand and receive all funds due the Association, together with the bequests and donations. He shall, under the direction of the House of Delegates sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be counter-signed by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President of the Association or the Chairman of the Council is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Council. The Treasurer shall subject his accounts to an annual audit under the direction of the Council. He shall render an annual account of his doings and the state of all Association funds.

Section 7. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and By-Laws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Chapter VII. The Council

Section 1. The Council shall be the executive body body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred on the House of Delgates by the Constitution and By-Laws. The Council shall consist of the duly elected councilors. The President, the President-elect, the three Vice-presidents, the immediate Past-

president, the Speaker of the House of Delegates, the Secretary, the Treasurer and the Delegates to the American Medical Association shall be ex-officio members of the Council with the right to vote. The Executive Committee of the Council shall consist of the President, the President-elect and the Secretary of the Association, together with the Chairman of the Council, Vice-chairman of the Council and two additional councilors to be elected annually by the Council. Between sessions of the Council, the Executive Committee shall exercise all of the powers belonging to the Council except those powers specifically reserved by the Council to itself.

Section 2. The Council shall hold daily meetings during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three councilors. It shall meet on the last day of the Annual Session of the Association for reorganization and for the outlining of the work for the ensuing year. At this meeting it shall elect a chairman and secretary, and it shall keep a permanent record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided which report shall include an audit of the account of the Secretary and Treasurer and other agents of this Association and shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. In the event of a vacancy in any office the Council may fill the same until the annual election.

Section 3. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the county societies and their members. The necessary traveling expenses incurred by Councilor in the line of his duties herein imposed may be allowed by the House of Delegates upon a proper itemized statement, but this shall not be construed to include his expense in attending the Annual Session of the Association.

Section 4. Collectively the Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates of the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or a county society upon which appeal is taken from the decision of an individual Councilor. Its decision in all such cases shall be final.

Section 5. The Council shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation and other important matters to the public and the lay press. Such communications shall be signed by the President of the Association and the Chairman of the Council as such.

Section 6. The Journal of the Kentucky State Medical Association shall be the official organ of the Association and shall be published under the supervision of the Council. The Editor of the Journal shall be elected by the Council. All money received by the Journal or any member of its staff shall be paid to the Treasurer of the Association on the first of each month. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 7. All reports on scientific subjects and all scientific discussions and papers read before the Association shall be referred to the Kentucky Medical Journal for publication. The editor, with the consent of the Councilor for the District in which he resides, may curtail or abstract papers or discussions, and the Council may return any paper to its author which it may not consider suitable for publication.

Section 8. All commercial exhibits during the Annual Session shall be within the control and direction of the Council.

Section 9. In the event the office of one of the District Councilors is vacated between the meetings of the House of Delegates, the President of the Association may call a meeting of the delegates of record in the Headquarters Office from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Council, which will elect a Councilor from them to serve until the next meeting of the House of Delegates.

Section 10. A Medico-Legal Administrator shall be appointed to serve for a term of three years by the Council of the Association. The Executive Committee of the Council shall act in an advisory capacity to the Administrator. The Association, through the Administrator, shall provide its members in good standing a defense against unjust professional liability suits upon request by a member physician involved. The Administrator, acting under the general direction of the Executive Committee, shall select and fix the compensation for an attorney who shall act as the general counsel in these matters and, if required, select additional counsel.

Section 11. The Council shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Council. His compensation shall be fixed by the Council. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and By-Laws upon the officers, councilors, committees, boards, and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the annual sessions, the meetings of the House of Delegates, the meetings of the Council, as many of the committee meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers and committees of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Council.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees of their appointments and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come

into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall, within thirty days preceding each annual session, submit his financial books and records to a certified accountant, approved by the Council, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners of the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky State Medical Association under supervision of the Council and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Council, or the President, and shall employ such assistants as the Council may direct. He shall serve at the pleasure of the Council, and in the event of his death, resignation, or removal, the Council shall have the power to fill the vacancy. From time to time, or as directed by the Council, he shall make written reports to the Council and House of Delegates concerning his activities and those of the Headquarters Office.

Chapter VIII. Committees

Section 1. The Standing Committees shall be as follows:

A Committee on Scientific Assembly and Arrangements
A Committee on Public Information and Service
A Committee on Medical Education and Economics
A Committee to Study Constitution and By-Laws
A Legislative Committee

and such other committees as may be necessary. The Headquarters Office at 620 South Third Street, Louisville 2, Kentucky, shall be the headquarters for all committees and activities of the Association except as may be specifically authorized by the Executive Committee. Committees shall be appointed by the President of the Association in conference with the Secretary unless otherwise specified. The President, Secretary and General Manager, and Executive Secretary shall be ex-officio members of all committees serving without power to vote except as otherwise specified.

Section 2. The Committee on Scientific Assembly and Arrangements shall consist of five members. The President of the Association shall be a member and Chairman of the Committee. The President-Elect shall be a member of the Committee and Vice-Chairman thereof. The remaining three members shall serve for terms of three years each, with the term of one member expiring each year and the vacancy filled by appointment of the President. The Committee shall determine the character and scope of the scientific proceedings of the Association, subject to the constitution and by-laws and the instructions of the House of Delegates or of the Council, and to that end may invite the Chairman of its subcommittee to meet and consult with it. Thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers discussions and other business shall be presented, which program shall be adhered to by the Association as nearly as practicable. No county society as such shall serve as host society to the annual meeting.

Section 3. A Committee on Public Information and Service shall be appointed by the Council of the Association whose members shall serve at the discretion of the Council. The Council will annually designate its chairman. It shall be the duty of this committee to keep in active touch with public opinion. It shall keep the public informed of such developments that will constitute a service to the public. It shall promote such immediate and long-range educational programs, both to the public and within the profession, as are deemed in the best interest of both. Its work shall be done with dignity becoming a great profession and that wisdom which makes effective its work and influence.

Section 4. The Committee on Medical Education and Economics shall be appointed by the Council whose members shall serve at the pleasure of the Council. The Council shall annually designate the chairman of the committee. It shall be concerned with and responsible for all matters of Medical Education and Medical Economics which shall be within the province of the State Medical Association It shall continually strive to serve as a liaison between the public and the Medical Association in those matters.

Section 5. The Committee to Study the Constitution and By-Laws shall be appointed by the Speaker of the House of Delegates acting in conjunction with the Vice Speaker and the Nominating Committee and shall make a continuing study of the Constitution and By-Laws. The Committee shall annually recommend to the House of Delegates such revisions as changing times and conditions dictate.

Section 6. The Legislative Committee shall be appointed annually by the Council of the Association whose members shall serve at the pleasure of the Council. The Council shall each year designate the chairman of the committee. Under the direction of the Council, it shall represent the Association in securing and enforcing legislation in the interest of public health and the science of medicine.

Chapter IX. Assessments and Expenditures

Section 1. The assessment of thirty five dollars per capita on the membership of the component societies is hereby made the annual dues of this Association. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association on the first day of January in each year.

Section 2. Any county society which fails to pay its assessments, or make the report required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have the prior approval of the Council before they can become effective.

Chapter X. Rules of Conduct

The principles set forth in the Principles of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

Chapter XI. Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in

Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XII. County Societies

Section 1. All county societies now in affiliation with the State Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one state-wide society of worthy Negro physicians who are not members of any county society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association. When more than one county society exists friendly overtures and concessions shall be made with the aid of the Councilor of the District if necessary and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Section 5. Each county society shall judge of the qualifications of its own members, but as such societies are the only portals to this Association, every reputable and legally registered physician who is practicing, or who will agree to practice nonsectarian medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member. All active members of the component county societies shall be active members of the Kentucky State Medical Association.

Section 6. Any physician who may feel aggrieved by the action of the society of the county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, which upon a majority vote may permit him to become a member of an adjacent county society.

Section 7. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual councilors in district and county work, effort at conciliation and compromise shall precede all such hearings.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician living in or near a county line may hold membership in that county most convenient for him to attend, on permission of the county in whose jurisdiction he resides.

Section 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county, and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do post-graduate and original research work, and to give the society the first benefit of such labors. Official position and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers each component society shall elect a delegate or delegates to represent it in the House of Delegates of the Association. The term of a delegate is from the beginning of the annual meeting of the House to which he was elected to serve to the beginning of the next annual meeting, but it may be for one or more years at the discretion of the county society. Each component society may be represented by one delegate for each 25 members in good standing plus one delegate for one or more members in excess of multiples of 25. Provided, however, that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the secretary of this Association not later than 45 days before the next annual session. It shall be the obligation of the county medical society which elects delegates to serve more than one year to provide the KSMA Headquarters Office with a completed certified list of delegates to represent that county for that particular year.

Section 13. The Secretary of each county society shall keep a roster of its members and a list of non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each county society shall report to the Kentucky Medical Journal full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

Section 15. County societies may invite Dentists, Pharmacists, Funeral Directors, or other professional persons to become Associate Members of the County Society but such Associate Members shall not have any privileges or representations in the State Association.

Chapter XIII. Amendments

These by-laws may be amended by any annual session by a two-thirds vote of all the delegates present at that session, after the amendment has been laid on the table for one day.

"...THE MERCURIALS
HAVE PROLONGED
THE WORKING PERIOD
AND LIFE SPAN OF
COUNTLESS SUFFERERS
FROM CONGESTIVE
HEART FAILURE..."*

TABLET
NEOHYDRIN®

*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

00756

Malpractice Prophylaxis

With us
"know-how" in prevention, defense and negotiation reduces the filing of malpractice claims and suits

Specialized Service
makes our doctor safer

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE Office
Calvin Bimer, Representative
3119 Hewitt Ave.
Tel. Glendale 8-3060
If no answer, call Juniper 3-3636

CROCKER-FELS COMPANY
SERVING PHYSICIANS AND HOSPITALS SINCE 1882



If you're looking for an unusually attractive examining room suite, unusually serviceable equipment, and special features to make your work easier—you'll find them in Hamilton's Steeltone, shown above. And it's available in an array of decorators' colors: white deluxe, cream white, jade green, washington blue, coral, and silver metallic.

The name Hamilton is synonymous with quality.

The Crocker-Fels Company

624 S. THIRD ST. CLay 8855 LOUISVILLE, KY.

Ask about our liberal financing plan

PROVEN
PAIN CONTROL
with safety

GRADATIONS OF ANALGESIA

'TABLOID' 'EMPIRIN' COMPOUND®
Acetophenetidin gr. 2½, Acetylsalicylic Acid gr. 3½, Caffeine gr. ½

'TABLOID' 'EMPIRIN' COMPOUND
with CODEINE PHOSPHATE gr. ⅛, No. 1 (N)

'TABLOID' 'EMPIRIN' COMPOUND
with CODEINE PHOSPHATE gr. ¼, No. 2 (N)

'TABLOID' 'EMPIRIN' COMPOUND
with CODEINE PHOSPHATE gr. ½, No. 3 (N)

'TABLOID' 'EMPIRIN' COMPOUND
with CODEINE PHOSPHATE gr. 1, No. 4 (N)

(N) subject to Federal Narcotic Law

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N. Y.



the Emblems of RELIABLE PROTECTION

We cordially invite your inquiry
for application for membership
which affords protection against
loss of income from accident and
sickness as well as benefits for
hospital expenses for you and
all your dependents.

ALL PREMIUMS COME FROM
PHYSICIANS SURGEONS DENTISTS
ALL BENEFITS GO TO

$4,500,000 ASSETS
$24,500,000 PAID FOR BENEFITS
SINCE ORGANIZATION

Since 1902

PHYSICIANS CASUALTY
AND
HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

EVERY WOMAN
WHO SUFFERS
IN THE
MENOPAUSE
DESERVES
"PREMARIN"®

widely used
natural, oral
estrogen

AYERST LABORATORIES
New York, N. Y. • Montreal, Canada
5646

PROVEN
PAIN CONTROL
with sedation

GRADATIONS OF ANALGESIA
with light sedation

'EMPIRAL'®
Phenobarbital gr. ¼
Acetophenetidin gr. 2½
Acetylsalicylic Acid gr. 3½

'CODEMPIRAL'® No. 2(N)
Codeine Phosphate gr. ¼
Phenobarbital gr. ¼
Acetophenetidin gr. 2½
Acetylsalicylic Acid gr. 3½

'CODEMPIRAL'® No. 3(N)
Codeine Phosphate gr. ½
Phenobarbital gr. ¼
Acetophenetidin gr. 2½
Acetylsalicylic Acid gr. 3½

(N) subject to Federal Narcotic Law

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N. Y.

only

1/2 to 1/10 as much

aqueous vitamin A needed
as compared
to oily vitamin A

...in acne,
eczemas,
dry skin

Now—imposing evidence demonstrates the clinical superiority of aqueous vitamin A over ordinary oily vitamin A in these dermal disorders† . . .

	aqueous vitamin A (Aquasol A)	ordinary oily vitamin A
acne	25,000 to 50,000 units daily	up to 500,000 units daily
eczema chronic	25,000 to 50,000 units daily	50,000 to 500,000 units daily
excessively dry skin	60,000 to 100,000 units daily	100,000 to 300,000 units daily

aquasol A
capsules

three separate potencies of natural vitamin A per capsule . . . in water-soluble form:

25,000 U. S. P. Units

50,000 U. S. P. Units

100,000 U. S. P. Units

*oil-soluble vitamin A made water-soluble with sorethytan esters; protected by U. S. Patent No. 2,417,299.

Samples and† detailed literature on request.

first and **only** aqueous* natural vitamin A in capsules

Bottles of 100, 500 and 1000 capsules

u. s. vitamin corporation
(ARLINGTON-FUNK LABORATORIES, division)
250 East 43 Street • New York 17, N. Y.

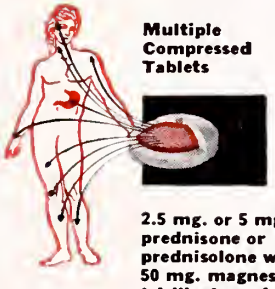
in inflammatory skin diseases



all the benefits of the "predni-steroids"
plus positive antacid action
to minimize gastric distress

ROUTINELY ACHIEVED WITH

'Co-Deltra'
(Buffered Prednisone)



Multiple Compressed Tablets

'Co-Hydeltra'
(Buffered Prednisolone)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are the trademarks of* MERCK & CO., INC.

NEW

For Pain-Free

of everyday

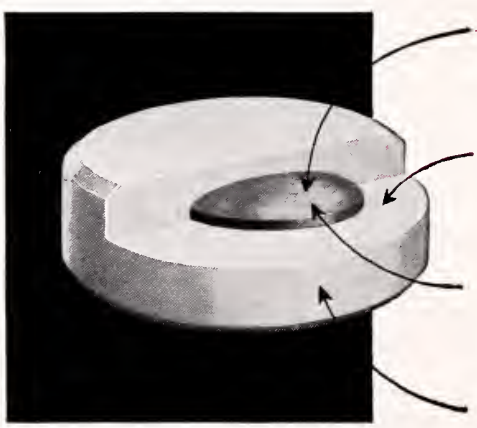
In "Rheumatism"*

Multipl

TEMP

combine:

THE PROPER FORMULA
PROPERLY FORMULATED



Physical separation of the steroid component from the aluminum hydroxide as provided by the Multiple Compressed Tablet construction assures full potency and stability of prednisolone.

PREDNISOLONE (*1 mg.*)

+

ASPIRIN (*0.3 Gm.*).....

+

ASCORBIC ACID (*50 mg*

+

ANTACID (*0.2 Gm.*).....

*Early rheumatoid arthritis
Rheumatoid spondylitis
Osteoarthritis
Still's disease
Psoriatic arthritis
Bursitis
Synovitis
Tenosynovitis
Myositis
Fibrositis
Neuritis

Performance

ctivities

Patients



Compressed Tablets

TEMPOGEN®

..... for anti-inflammatory, anti-rheumatic benefits *at effective low dosage.*

..... for analgesia plus additional anti-rheumatic activity.

..... for anti-stress support that guards against adrenal ascorbic acid depletion.
(Ascorbic Acid present as 60 mg. Sodium Ascorbate.)

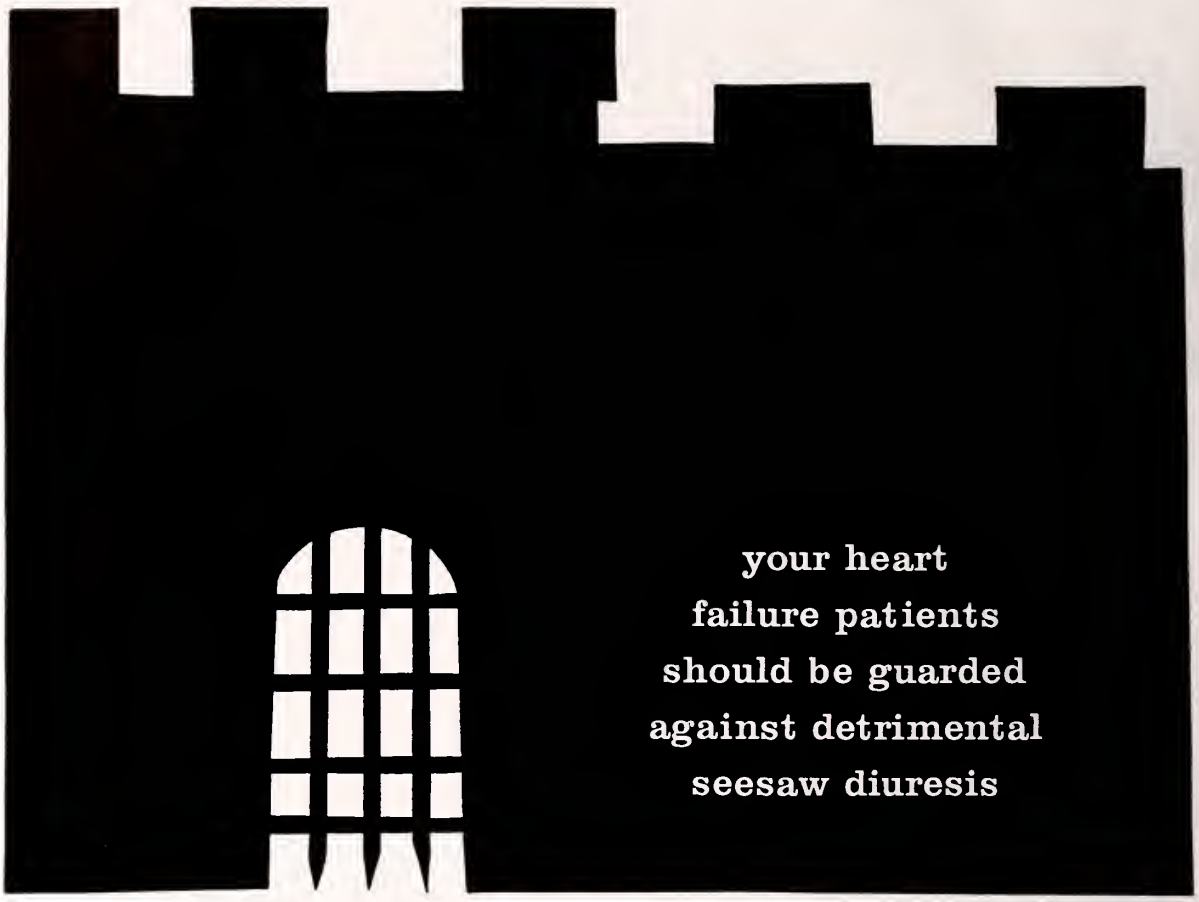
..... dried aluminum hydroxide gel minimizes the possibility of gastric distress.

DOSAGE: *1-4 TEMPOGEN Tablets t.i.d. or q.i.d. (TEMPOGEN Forte, 1 or 2 tablets t.i.d. or q.i.d.) for one or two weeks. Then lower by 1 tablet every four or five days to maintenance level.*

SUPPLIED: *TEMPOGEN and TEMPOGEN Forte —in bottles of 100 Multiple Compressed Tablets. (TEMPOGEN Forte provides 2 mg. of prednisolone.)*

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.



PATIENTS IN FAILURE NEED AN ORGANOMERCURIAL

Limiting dosage to once daily to avoid refractoriness, or omitting alternate days to circumvent gastrointestinal irritation—necessary with some diuretics—results in a seesaw of diuresis with fluid reaccumulation and recurrent strain on the already failing heart.

With the organomercurials, dosage is individualized and administered as needed, to produce sustained, dependable diuresis.

TABLET

NEOHYDRIN®

BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

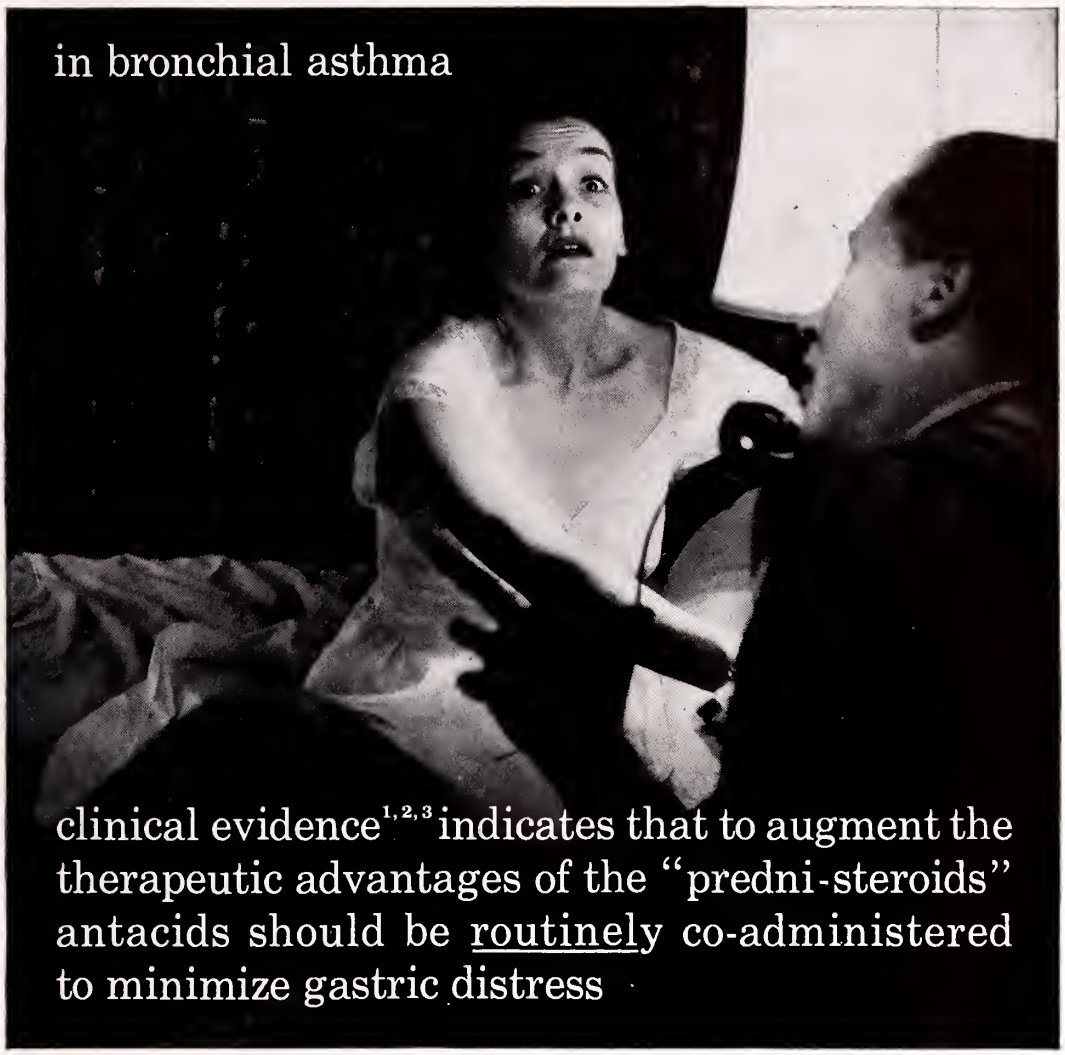
a standard for initial control of severe failure

MERCUHYDRIN® SODIUM

BRAND OF MERALLURIDE INJECTION

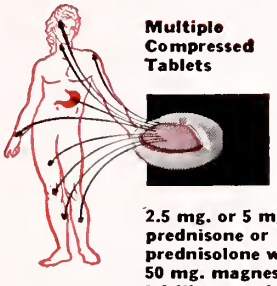
LAKESIDE

02556



ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Buffered Prednisolone)



Multiple Compressed Tablets

'Co-Deltra'
(Buffered Prednisone)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al, J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al, J.A.M.A.* 158:459, (June 11,) 1955.

MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are the trademarks of* MERCK & CO., INC.

Erythromycin in the treatment of osteomyelitis

8/3/55

CASE SUMMARY

On 6/2/55, patient, male, age 28, fell on an old fracture and refractured the middle third of the right femur, superimposed on an old osteomyelitis.

On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

On 8/3, the cast was removed and leg recast. Wound was in good condition with minimal drainage.

Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

Result: erythromycin aided healing of the old osteomyelitis and kept the infection under control.

* *Communication to Abbott Laboratories*

pecific against

occic infections

Specific—because you can actually pinpoint the therapy for coccic infections. That's because most bacterial respiratory infections are caused by staph-, strep-and pneumococci. And these are the very organisms most sensitive to ERYTHROCIN—even when in many cases they resist other antibiotics.

filmtab®

Erythrocin®

(Erythromycin, Abbott)
STEARATE

ith little risk of

erious side effects

Low toxicity—because ERYTHROCIN rarely alters intestinal flora. Thus, your patients seldom get gastroenteral side effects. Or loss of vitamin synthesis in the intestine. Virtually, no allergic reactions, either. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), bottles of 25 and 100. Abbott

filmtab®

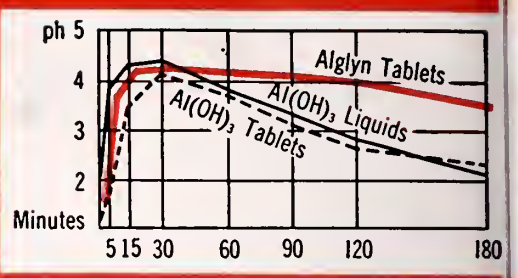
Erythrocin®

(Erythromycin, Abbott)
STEARATE

® Filmtab—film-sealed tablets; pat. applied for

609216

Announcing Revision of N.N.R. Monograph for



ALGLYN

dihydroxy aluminum aminoace

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

Brayton PHARMACEUTICAL COMPAN

CHATTANOOGA 9, TENNESSEE

CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of
mental and nervous disorders, and
addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director

MEDICAL-DENTAL BUSINESS BUREAU, INC.
227 HEYBURN BUILDING — P. O. BOX 1465 WAbash 6725
334 W. BROADWAY
LOUISVILLE, KENTUCKY

Gentlemen, I am interested in talking with you about the subjects checked below.

See me at (address).....on (date).....at (hour).....

Doctor.....

( ) **Practice Survey and Recommendations**
( ) **Financial Records and Reports**
( ) **Professional Management Service**
( ) **Long-Term Financial Planning**
( ) **Tax Returns**
( ) **Other:**
( ) **Centralized Bookkeeping** (Statements to Patients)
( ) **Pre-Collection Program**
( ) **Partnership Formation**
( ) **Sale of Practice**
( ) **Collections**

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Clearview
On The Kratzville Road
EVANSVILLE, IND.

TELEPHONE 5-6181

A PRIVATE HOSPITAL FOR THE TREATMENT OF PATIENTS SUFFERING FROM MENTAL ILLNESS, ALCOHOLISM AND DRUG ADDICTION.

SEPARATE BUILDINGS FOR DISTURBED AND CONVALESCENT PATIENTS.

Equipped for Surgery
ELECTROENCEPHALOGRAPH — CLINICAL LABORATORY—EKG AND BMR EQUIPMENT—STEREOSCOPIC X-RAY — HYDROTHERAPY.

ALBERT J. CREVELLO, M.D.
Diplomate, American Board of Psychiatry & Neurology, Inc.
MEDICAL DIRECTOR



KNOWN and RESPECTED FOR A DECADE...

ATLAS INJECTABLES

Every ATLAS injectable is manufactured in our own new, ultra-modern laboratory under strictest controls. Continued research and testing assures the finest standard injectables as well as distinctive new formulae as they are perfected... Potencies and purity guaranteed, yet a realistic pricing policy makes them readily usable in every case.

Here is our latest Specialty...

RESERPINE **2.5 mg./cc. in 2 cc. Ampules pkgd. 10 ampules per box**

Order today from our representative or direct from our manufacturing laboratories. Complete medical information sent upon request.

ATLAS PHARMACEUTICAL LABORATORIES

13211 Conant Avenue **Detroit, Michigan**



TELEPHONE 650

PLEASANT GROVE HOSPITAL

ANCHORAGE KENTUCKY

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Member of the American Hospital Association and National Association of Private Psychiatric Hospitals

Four modern buildings, separate for men and women Individual rooms. All buildings equipped with radio. Recreation.

Hydrotherapy, Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

L. A. BUTTERFIELD,
Hospital Administrator

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M.D., Neuropsychiatrist
Medical Director

T. J. SMITH, M.D., Associate

Call KSMA at JUniper 5-5815

☆ ☆ ☆ ☆ ☆ ☆

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)

(The Pioneer Postgraduate Medical Institution in America)

ANESTHESIOLOGY

A three months full time course covering general and regional anesthesia with special demonstration in the clinics and on the cadaver of caudal, spinal, field blocks, etc.; instruction in intravenous anesthesia, oxygen therapy, resuscitation, aspiration bronchoscopy; attendance at departmental and general conferences.

DERMATOLOGY AND SYPHILOLOGY

A three year course, fulfilling all the requirements of the American Board of Dermatology and Syphilology. Also seminars for specialists, for general practitioners, and in Dermatopathology.

For Information about these and other courses Address: **THE DEAN, 345 WEST 50th St., New York 19, N. Y.**

WAYSIDE HOSPITAL

168 North Broadway • Lexington, Kentucky

A private psychiatric hospital offering modern diagnostic and treatment procedures.
Approved by American Medical Association
Member of American Hospital Association
Member of National Association of Private Psychiatric Hospitals

STAFF

H. Halbert Leet, M.D.
Carl Wiesel, M.D.
William V. Walsh, M.D.
John H. Rompf, M.D.
Irving A. Gail, M.D.
Wm. N. Lipscomb, M.D.
Orcena F. Knepper, M.D.

Edward L. Houchin, *Administrator*

Phone: 2-2050

OCULISTS' PRESCRIPTIONS EXCLUSIVELY

MUTH OPTICAL COMPANY

Prescription Opticians

665 S. 4th **Brown Hotel Building** **Louisville 2**

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 5, 6, 7 and 8, 1957

PALMER HOUSE, CHICAGO

Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist.

Panels on Timely Topics — Daily Teaching Demonstrations

Medical Color Telecasts

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

PEACE OF MIND FROM OFFICE AND BUSINESS WORRIES

OUR SERVICES COVER:

Available

- Tax Returns
- Bookkeeping
- Delinquent Accounts (No Commission)
- Office Routines
- Office Planning
- Instructing Personnel
- Fees
- Partnerships
- Hospitals
- Clinics
- Counselling - Investments Insurance

PROFESSIONAL BUSINESS MANAGEMENT

ASSOCIATES:

Clayton L. Scroggins
John R. Lesick
Richard D. Shelley
Hubert G. Stiffler
Daniel L. Zeiser
Richard J. Conklin

FOR DOCTORS ONLY

CLAYTON L. SCROGGINS ASSOCIATES

ESTABLISHED: 1945
WOodburn 1-1010

141 West McMillan Street
Cincinnati 19, Ohio

I would like to talk with one of your Kentucky representatives.

Name.....

Address.....

.....Telephone.....

All Services Completely Confidential

"the most critical inspection yet devised for an eye-glass lens"--

Your prescription filled by us will be processed to the prescription with first quality materials; the glass and surfaces will be tested for precision of workmanship—and your lenses checked for accuracy of power —only a perfect lens passes the Southern Optical test.



CONTACT LENSES
(Fluidless Lacrilens—Microlens)

Southern Optical COMPANY

ARTIFICIAL EYES
(Custom Plastic—Glass)

HOME OWNED SINCE 1897

4th and Chestnut
334 W. Broadway
LOUISVILLE

GUILD OPTICIANS

NEW CASTLE SANITARIUM

Telephone 3621
NEW CASTLE, KY.

For the care of
CHRONIC, CONVALESCENT AND GERIATRIC PATIENTS

Member of the American Hospitol Association
Member of the American Assn. of Nursing Homes
Licensed and Approved by the State of Kentucky

SPECIAL DIETS PREPARED — ELECTRO-THERAPY TREATMENTS AVAILABLE

PRIVATE PHYSICIAN AVAILABLE AT ALL HOURS

24-HOUR EFFICIENT AND CHEERFUL NURSING CARE

REASONABLE RATES
New Selectemp Madulated Steam Heat With Filtered Air For Maximum Comfort and Safety
Protected Throughout With Automatic Fire Detection and Alarm System

IRA O. WALLACE, Administrator

X-Ray Machine

100 MA Fisher with fluoroscopy
$1500 including developing tank, safety light, gloves and apron
Present monthly payments of $71.50 which may be assumed by the buyer

Contact—Dr. John A. Wimberly
Hinkle Bldg.
Richmond, Ky.

SECLUSION MATERNITY



FAIRMOUNT HOSPITAL

FOR UNMARRIED GIRLS
Est. 1909

Write for Information

HELEN AMOS
4911 East 27th St.
Kansas City, Mo.
Phone: WA. 3-3577

Private sanitarium with certified obstetrician in charge. Folder fully describing services FREE on request. Early entrance advised.

Rates reasonable. In certain cases work given to reduce expenses.

Index

The Journal

of The

KENTUCKY STATE MEDICAL ASSOCIATION

Edited by

Guy Aud, M.D.

Under Supervision of the Council

Volume Fifty-Four

JANUARY THROUGH DECEMBER

1956

SCIENTIFIC ARTICLES

A

Anticoagulants in Myocardial Infarctions, 431
Anxiety, 963

C

Cancer of the Genitourinary Tract, 418
Case for Social Medicine, 246
Changing Concepts in the Management of Eclampsia with Special Emphasis on Hypotensive Drug Therapy, 862
Chlorpromazine in a State Hospital, 587
Clinical and Metabolic Effects of Prednisone and Prednisolone in Rheumatoid Arthritis, 131
Clinical Partitions in Pediatrics, 227
Clinical Otosclerosis—Fenestration or Stapes Mobilization, Closure of Interatrial Septal Defects, 336
Combined Laryngectomy and Neck Dissection in Continuity for Carcinoma of the Larynx, 345
Congenital Mucosal Diaphragm of the Pyloric Antrum, 149
Current Status of Biliary Surgery, 505

E

Esophageal Hiatus Hernia, 954
Evaluation of Reserpine and Methyl Phenidylacetate Used Separately and in Combination in Chronic Psychotic Patients, 785
Evaluation of Vagotomy and Pyloroplasty in the Treatment of Duodenal Ulcer, 602
Eye Injuries, 240

F

Fire and Explosion Hazards With Flammable Anesthetic Agents and Their Control, 27
Fluid and Electrolyte Balance in Renal Disease, 47

G

Gastric Ulcer—Criteria for Determining Method of Treatment, 327

H

Heart Disease in Pregnancy, 36
Hemangiomas, 783

I

Implantation Carcinoma in the Incision Attributable to Desquamated Malignant Cells, 859
Indicated Status of Thrombo-Endarterectomy, 33
Induction of Labor With its Indications and Complications that May Arise From the Use of Pituitary Extract and Pitocin, 421
Injuries of the Urinary Tract Stressing Those Due to Gynecological Surgery, 855
Intestinal Obstruction from the Radiological Point of View, 499

M

Management of the Unconscious Patient, 157
Medical Management of Liver Disease, 710
Method of Treatment of Alcoholism and the Results, 255
Modern Concepts in the Treatment of Goitre, 866

N

Neck Dissection, 947

O

Oblique Upper Abdominal Incision, An, 234
Office Management of Conductive Deafness, 330
Open Method of Burn Therapy, 155
Oral Surgery Cases of Interest to the Physician, 249

P

Papanicolaou Procedure As an Aid in the Early Diagnosis of Cancer of the Cervix, 705
Pediatric Anesthesia, 414
Pheochromocytoma, 510
Present Concepts of Abnormalities in Hemoglobin Structure, 411
Propapse of Fallopian Tube After Vaginal Hysterectomy Report of Three Cases, 503

R

Residual Tuberculous Disease after Chemotherapy, 610
Retropubic Prostatectomy for the Benign Gland, 227
Rheumatoid Arthritis and What Can be Done About It, 771
Role of the Medical Department in Today's Navy, 338

S

Seasonal Allergy, 137
Selection of Patients for Radical Mastectomy, 1047
Some Effects of General Anesthetic Agents on the Heart, 594
Study of Tuberculosis Cavities by Contrast Media and Other Methods, 424
Surgical Maturation of The Ileostomy, 144
Surgical Measures for the Relief of Pain, 779
Surgical Treatment of Lymphedema, 590

T

Treatment of Chronic Venous Insufficiency, 524

U

Urologic Pathology of Interest to the General Practitioner, 703
Urologic Perspective of Abdominal Tumors, 598
Use of Antibiotics in the Treatment of Pulmonary Tuberculosis, 347
Use of Cortisone in Aged Patients with Acute Infections, 236
Use of Trypsin in Inflammation, 43
Use of Varidase in Perforating Appendicitis, 351

V

Variations in the Disease, Pulmonary Tuberculosis, 707
Virus Diseases and Vaccines, 521

W

Wedge Amputation for Gunshot Wounds of the Metatarsus and the Metacarsus, 959
What Would I Do If I Had an Ulcer, 870

SCIENTIFIC ARTICLES LISTED BY AUTHOR

A

Augustine, Robert W., 959

B

Beatty, Oren A., 424
Best, Maurice, 131
Bland, C. Brinley, 36
Blodgett, William A., 236
Boniface, Kenneth, 594
Bosworth, N. Lewis, 227
Bryant, J. Ray, 954

C

Cole, Julian B., 421
Collier, Henry S., 234

D

Davis, David A., 594
Davis, W. Burford, 954
Derlacki, Eugene L., 330
Del Toro, Russell A., 510
Doll, Stanley G., 47
Dorton, Howard E., 602
Dragstedt, Lester R., 870

E

Ensign, Dwight C., 771

F

Floyd, John B., Jr., 33, 783
Fox, W. Walter, 785

G

Gernert, E. R., 347
Gettlefinger, Wilfrid C., 521
Gott, J. Richard, Jr., 710
Gragg, Logan, 587
Grantham, Everett G., 779
Graves, Stuart, Jr., 431
Greene, George C., 862

H

Hagan, Hart, 144, 505
Hagan, William, 144, 505
Hall, D. P., 859
Harter, John S., 954
Hendon, James Robert, 236
Hower, Frank B., 249

J

Johnson, W. O., 503
Juers, Arthur L., 1056

K

Kappes, W. Carl, 866
Kaufman, Maurice, 137
Kratz, Robert C., 345
Kullman, Harold J., 327

L

Lee, W. Vernon, 705

MC

McClendon, Robert, 131
McPheeters, Harold, 785

M

Mack, H. Burl, 963
Mahr, Merle, 959
Marshall, Thomas M., 157
Mayer, Lloyd, 137
Medlar, E. M., 610, 706
Minish, Lawrence T., Jr., 236
Moore, Condict, 947
Morrison, O. B., Jr., 338
Muller, William H., Jr., 336

N

Neustadt, David H., 131

O

Olash, F. Albert, 131

P

Pirkey, Everett L., 499
Poweleit, Alvin C., 345

R

Reeh, Merrill J., 240
Rubel, W. Fielding, 954
Ruff, J. Douglas, 411

S

Sanders, George B.,
Scardino, Peter L., 246, 418
Sehlinger, George A., 855
Seligman, Bert, 43, 524
Sigler, John W., 771
Silverman, Frederic N., 229
Shepard, R. D., 149
Swartz, William T., 149, 590

T

Terhune, William B., 255
Thomas, George J., 27
Threlkel, F. Hays, 414

U

Undem, Dale, 499

W

Weeter, John Calvin, 155
Weddle, Richard H., 351
Whitcher, Charles, 594
Woods, Frank M., 598, 703

EDITORIALS

A

Acute Duodenal Ulcer, 68
Adolescent Adults, 440
Automobile Safety, 970
Auxiliary Activities Acclaimed, 876

B
Bon Voyage, 165
D
Dr. Abraham Flexner, Kentuckian, 718
E
Excision of the Rectum Two Team Technic, 970
F
Factors in Medical Care, 266
From the Editor, 439
H
Hernia in Infants and Children, 67
How Deep is Your Conviction?, 1090
I
Importance of Leukoplakia in Oral Cancer, The, 617
M
Medical Statesmanship on Medical Politics, 166
Methodist-Evangelist Hospital, The, 795
N
Nurses Look at the Nursing Problem, 877
Nursing Problem, The, 718
O
Obstetrics in Rural Practice, 265
Oral Treatment of Diabetes Mellitus, 532
P
Plea for the Fundamentals in Surgery, A, 357
S
Selling Sample Racket, 618
T
The Changing Face of Tuberculosis, 439
Trustee-Staff Relationships, 618
U
Underwood, Bruce, The Progenitor of Progress, 164
W
We Are Doing Better, 795
What Do Americans Think of the Medical Profession?, 531
What Does Blue Shield Mean to You?, 876
What Kind of a Medical School?, 358
Why?, 1090

SPECIAL ARTICLES

D
Disability Freeze, The, 616
E
End of an Era, 437
R
Report on the Eleventh National Conference on Rural Health, 615
S
Social Security—Big Item in '56, 55
State Hospitals and Discharge Procedure, 530
T
The People and Rural Health, 263

EDITORIALS AND SPECIAL ARTICLES BY AUTHOR

A
Atkinson, W. B., M.D., 166
B
Baughman, Branham B., M.D., 358
C
Casper, R. Burke, M.D., 265
Chambers, J. S., M.D., 358
Cox, David M., M.D., 718
Crawford, Paul M., M.D., 439
D
Denham, Harry C., M.D., 618
Dickinson, Lewis, M.D., 532
F
Flexner, Morris, M.D., 440
L
Lewis, Blaine, M.D., 67, 970
Love, Jesshill, M.D., 617
M
Morgan, Barbara N., 437
N
Norvell, Wyatt, M.D., 263, 615
O
Overstreet, Sam A., M.D., 68, 165, 266, 718, 795, 796
P
Pace, J. Vernon, M.D., 164
R
Rust, Richard J., M.D., 1090
S
Sonne, John J., M.D., 970
T
Thompson, Malcolm, M.D., 67, 970
Troutman, Woodford B., M.D., 439
W
Waldrop, Claude C., M.D., 1091
Warren, Cynthia N., R. N., 877

ORGANIZATION SECTION STORIES LISTED BY TITLE

A
Advisory Committee Named by TB Hospital Commission, 538
Alley, Rufus, M.D., Installed as President of APS, 720
Allied Medical Services Council Opposes HJ Resolution, 271
Allman, David, is President-elect of American Medical Association, 621
Alumni of U of L Hospitals Have Reunion June 26, 720
AMA Clinical Meeting Held on West Coast in November, 1092
AMA Clinical Session at Seattle, Nov. 27-30, 878
AMA Dues Paying Members Have Choice of Ten Journals, 170
AMA 1956 PR Institute Planned for August 29-30 in Chicago, 723
AMA Plans Three New Series of Radio Transcriptions, 170
AMA's Outstanding MD of '53, Dr. Greenwell, Dies May 8, 534
AMA President to Speak April 16 at Seminar Day Program, 267
AMA President-elect Speaks at CSOC March 29, Lexington, 441
AMA President Hess Speaks at Second Annual Senior Day, 443
Annual Meeting Program Released by Committee, 533
Annual Meeting Program Summary, 694
Annual Meeting Will Honor KSMA's President in 1876, 702
Awards Committee to Follow New Procedure at '56 Meet, 687
B
Better Distribution of Physicians in Needy Areas in KSMA Aim, 620
Big Sandy Seminar Held at Paintsville October 25, 978
Blue Shield Group Re-elects Dr. Pierce, 71
C
Cardiovascular Symposium Scheduled for January 20, 73
Chairman Pace to Read Report of KSMA Council Sept. 17, 684
Chandler Backs New Med. School at University of Kentucky, 170
Chest Disease Program Held at Paris Oct. 24, 978
Chest Ills Program Nov. 29 at Ashland, 987
Cincinnati Medical Academy 100 Years Old in February, 1092
Commencement P-G Course Planned in Louisville, June 4, 444
Complacency is Greatest Enemy, Dr. Hess Tells Physician, 69
Constitution and Bylaws of the Ky. State Medical Association, 1100
Consulting Architects Named for U of K Medical School, 444
Council Appointed Committees, 1956-1957,
Council Selects Dr. Troutman Secretary-Editor Pro tem, 169
Council Sets Deadline—April 1—for Paying KSMA Dues, 270
County Medical Leaders to Hear Top Experts from Both Coasts on Local PR and PS Matters, 167
Covington Surgeon Named KSMA President-Elect, 972
D
Defense Dept. Works with States on Medicare Plans, 879
Diabetes Detection Drive Nov. 11-17, Support Urged, 878
Dr. Adams Represents KSMA at Civil Defense Meet in Chicago, 1092
Dr. Aud Named Editor in New Organizational Setup, 976
Doctors' Aides Organize at Milwaukee Meeting, 1093
Dr. Bell Succeeds Dr. Goldstein as Psychiatric Head, 977
Drs. Bordley, Stephen, Dodd, to Speak at Annual Meeting, 533
Dr. Burney Replaces Dr. Scheele as Surgeon General of PHS, 880
Dr. E. Strode Urges Physicians to Name Award Candidates, 362
Dr. Elkin, Lancaster, Appointed to UK Board of Trustees, 360
Dr. Gaither is Guest Speaker at Joint 12-15th Meeting, 722
Dr. Gaither is Guest Speaker at Sixth District Meeting, 364
Dr. Howard Re-elected President at State Bd. of Health, 271
Dr. Lawson Named President at Seventh District Meet, 623
Doctor-Lawyer Relations to Be Shown in New Film, 1093
Dr. McCarty Named Chairman of SMA Council, 1092
Dr. Mahaffey to Head Council, Dr. Toomey is Vice-Chairman, 972
Dr. Massie' Named President of Kentucky Surgical Society, 536
Dr. Pierce Re-elected President of Blue Shield Organization, 71
Dr. Sparks Succeeds Dr. Vance as Speaker of the House, 976
Dr. Rust, Newport, Is Chairman of New KSMA Committee, 73
Dr. Toomey Announces Meeting of Sixth District, June 27, 534
Dr. Underwood Praised for Work in KSMA and Health Dept., 268
Downtown Hospital Site Favored According to Physician Poll, 73
E
Eighty Attend UMW Conference at Charleston, May 6, 535
Eight New Members Elected to Board of Consultants, 798
Eleven Hospital Projects Endorsed for US Aid, 880
Eleven Ky. Surgeons Inducted as New Fellows of ACS, 70
Eleven Specialty Groups Convene at Annual Meet, 979
Eleven Specialty Groups to Meet at 1956 Annual Meeting, 692
Eleventh Councilor District Holds Meeting at Berea, 1093
Expansion Continues in Medical Schools, 879
Expenses for Refresher Courses Deductible from Income Tax, 801
Expanded Medical Center is Proposed for Louisville, 445
Ex-Vanderbilt Professor Joins UL Medical School Staff, 271
F
Fifteen Kentuckians Go to SMA Birthday Party, 978
Fifty-four Kentucky Physicians Attend SMA Meeting in Houston, 72

First Blue Shield Forum Attracts Kentucky Physicians, 878
First Medical Education Week Scheduled for April 23-29, 272
Five KSMA District Councilors to be Elected September 19, 687
Five KSMA Members Speak at Women's Club Meeting, 623
Folsom Names Group to Work with HEW on Hospitals, 978
Ford Foundation Grants U. L. Med. School $500,000, 987
Foreign MD Evaluation Program Approved by AMA Trustees, 624
Forty-six Hospitals Get Ford Grants Amounting to $1,061,750, 622
Four Louisville Physicians Speak at 13th District Meeting, 362
Four KSMA Councilor Districts Have Meetings During April, 537
Four Specialty Groups Name Annual Meeting Speakers, 619
Fulton's Dr. D. L. Jones Named "1955 Citizen of the Year," 446

G

Gaines, Frank M., M.D., Louisville, Honored by Station WHAS, 171
Gaither, Gant, M.D., Announces Senior Day Committee, 72
Gaither, Gant, M.D., Reports on '56 Annual Meet Plans, 441
General Practice Academy Plans Annual Meeting, April 18, 20
Glasgow MD Named President of Sixth District Group, 72
Golf Tournament to be Held at Louisville Country Club, 702
Good Attendance Recorded at Annual Meeting, 977
Gov. Chandler is Guest Speaker at Eighth Annual KPHA Meeting, 445
Graves, G. Y., M.D., Honored in Chicago; Makes Talk, 621
Guest Speakers, 688

H

Honor Awards Presented to Drs. Molony and Coleman, 973
Hospital Accreditation Board Announces New Standards, 443
Hospital Accreditation Discussed by AMA House of Delegates, 620
House Acts on "Medicare" Fee Schedule, 974
House of Delegates Digest of Proceedings, 1061
House Revamps Committees, Considers Resolutions, 979
HR 7225, OASI, Are Big Topics as AMA's Delegates Meet, 71
Hoxsey Treatment is Worthless, Says Food-Drug Administration, 445

I

Increase in Nurses Still Does Not Satisfy Demand, 1093

J

J. A. Hodge Memorial Meeting, 695
Johnson County Society is Host at 14th District Meeting, 362

K

Kentucky Blue Shield Group Plans Seminar September 6, 719
Ky. Chapter ACS Elects Dr. Griswold President, 536
Ky. Chapter of ACS to Meet May 18 at French Lick, 359
Ky. PPS Offers New Service, to MD's and Communities, 989
Ky. Rural Health Council Begins Plans for '57 National Meet, 719
Ky. Rural Health Council Plans for National Conference, 972
Ky. Surgeons Honored at ACS Clinical Congress, 978
Kentucky Surgeons to Meet May 19 at French Lick, 270
KSMA Doctors to be Active at SMA Anniversary Meet, 878
KSMA House of Delegates to Meet Sept. 17 and 19, 682
KSMA Ninth Councilor District Sponsors Maysville Seminar, 537
KSMA Officers to be Elected at Second Session of House, 684
KSMA Represented on SMA Med. Student Program, 981
KSMA 12-15th Districts Plan Joint Meeting on June 28, 535

L

Louisville Industrial Physician Wins Presidential Award, 271
Louisville Pathologist Given $3,800 Outboard Cruiser, 798
Louisville Student AMA Chapter to Hear Walter Reed Doctor, 361

M

Mayfield MD Elected President of Kentucky OB-GYN Society, 364
Medical Association Establishes Physician Loan Program, 171
MD From Cabbage Patch is "Family Doctor of the Year," 446
MDs Can Name Award Candidates at County Officers Meeting, 170
Military Obligations Studied as Doctor Draft Ends, 979
Murray, Dwight, Inaugurated as President of the AMA, 623

Mc

McGrath, Past Presidents Share Luncheon Program, 976

N

National RH Meet is Best, Wyatt Norvell, M.D., Says, 361
Nationally Known MDs to Speak at Officers Conference March 29, Lexington, 69
Navy Will Need 380 Doctors, Dr. McCarty Announces, 622
New Commission to Study Needs of Indigents, 974
New Council is Governing Body of 4,000 Med. School Alumni, 1093
Nine Ky. MDs Participate in AMA Annual Meeting, 619
Nineteenth Edition, AMA Directory Released to Subscribers, 538
Nominating Committee to Hold First Session September 17, 686
Nominating Committee to Organize at County Officers Meeting, 169

O

Obesity Risks Discussed on TV by Jefferson County MDs, 879
October Conference Postponed, Re-scheduled for Spring, 73
One Hundred Eighteen KSMA Members Attend '56 AMA Annual Meeting, 621
One Hundred Fifty-Four Attend Annual Seminar at Ky. Lake June 12, 720
One Hundred Twenty-Five Physicians Attend Meeting of Sixth District June 27, 723

P

Patient's Hospital Expenditures Increase 116% in 10 Years, 804
Pediatrics Postgraduate Course Scheduled May 1-June 19, 360
Pediatrics Seminar Scheduled May 1 Thru June 19, 272
Pennsylvania Physician Named AMA's GP of the Year, 70
Physicians of Fourth District Meet in Bardstown July 19, 722
Physicians are Urged to Protect Family Finances, 880
Plans for '56 Annual Meeting are Nearing Completion, 797
Polio Vaccine Now Available at Local Drug Stores, 359
Postgraduate Medical Education Discussed, 70
Postgraduate Refresher Courses Innovation at '56 Meeting, 693
Postgraduate Symposium Held in Beaumont Inn, Harrodsburg, 362
Proposed Amendments to Constitution and Bylaws, 701
Public Opinion Survey Shows People Like Physicians, 360

R

Record Number of Exhibitors to Participate in Meeting, 687
Refresher Courses to be Feature of KSMA Annual Meet, 359
Regional Meetings Held to Aid Diabetes Detection, 879
Revised Version, Medical Ethics Presented at AMA Meeting, 719
Room Assignments for Meeting Announced by Dr. Gaither, 800
Rural Health Leaders Plan for National Conference, 1092
RH Meeting Jan. 19 to Feature Discussions, Dramatic Skit, 69

S

Scientific Movie Program Announced by Dr. Noer, 798
Scientific Movies Replace TV at 1956 Annual Session, 701
Sears-Roebuck Foundation Announces New MD Loans, 803
Seven Heart Clinics Now Serving Nearly 40 Per cent of State, 364
Seven Reference Committees to Operate at '56 Meeting, 684
Seventy-five Hear Gant Gaither, M.D., at Eight District Meeting, 537
Sister Agnes Miriam Elected President of KSARN, 981
Sixteen Medical Students Granted Medical Scholarship Loans, 719
Sixth Annual County Medical Officers Conference, 168
Sixth Councilor District Presents TB Panel, 1093
Sixth District Physicians Hear Dr. Gaither and Dr. Regen, 446
Sixty-four Technical Exhibitors to Display Products at '56 Annual Meeting, 802
Southern Medical Association to Celebrate 50th Birthday, 800
SMA's First Service Award to be Presented in 1956, 803
State Aid for Needy Sick Plan to be Studied by Commission, 720
Syracuse Dean Named Head of UK Medical School, 797

T

Teague, Russell E., M.D., Named Ky. Health Commissioner, 267
Ten Class Reunions Scheduled September 20 in Louisville, 701
Third Annual Kenlake Seminar is Scheduled for July 12, 535
Third Chest Disease Symposium Scheduled for August 29, 719
Thirteen Kentucky MDs Attend Clinical Meeting in Boston, 72
Three Physicians Reappointed to Medical School Committee, 722
Three Postgraduate Seminars Held During March, April, 362
Twelve Scientific Exhibits Scheduled for Meeting in September, 798
Two Hundred Forty Attend Annual Meeting of Fayette Medical Society, 535
Two Retired Louisville MDs Receive Achievement Awards, 538
Two Specialty Groups Added to 1956 Annual Meeting, 70

U

UL Med. School Due $500,000; Sets Up Scholarship Plan, 622
UMWA Representatives to Meet May 6 in West Virginia, 359
UMW Hospital in Middlesboro Opened in Late November, 73

W

Woman's Auxiliary, 34th Annual Meeting, 697

NEW

ATARAXOID is a unique, new combination of STERANE and ATARAX, which now permits simultaneous symptomatic control and reduction of attendant anxiety and apprehension in rheumatoid arthritis and other indications.

The added tranquilizer control, desirably easing mental stress, also directly assists clinical progress. It minimizes the chance of exacerbation related to emotional strain and facilitates patient confidence and cooperation in the therapeutic program toward maximum rehabilitation.

ATARAXOID exerts the anti-rheumatic, anti-inflammatory activity of STERANE distinctly superior to previous steroids, effective in radically reduced dosage, and with minimal disturbance of electrolyte and fluid metabolism.

The ataractic effect is a central neuro-relaxing action – the result of a marked cerebral specificity – free of mental fogging and devoid of any major complications: no liver, blood or brain damage. This peace-of-mind component is also used in the lowest dosage range.

Supplied: Each green, scored, ATARAXOID oral tablet contains 5 mg. prednisolone (STERANE) and 10 mg. hydroxyzine hydrochloride (ATARAX). Bottles of 30 and 100.



PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

the first and only ataraxic-corticoid

araxoid*

prednisolone and hydroxyzine

Pfizer

combining the newest, safest tranquilizer, ATARAX® + the newest, most effective steroid, STERANE® (prednisolone)

simultaneously **controls the symptoms and the apprehension**

In Rheumatoid Arthritis, other collagen diseases, bronchial asthma and inflammatory dermatoses

*Trademark

Relax the best way ... pause for Coke



continuous quality is quality you trust

DRINK Coca-Cola REG. U.S. PAT. OFF.

organomercurial diuretics "...permit ingestion of enough salt to make food palatable; without them, many patients would lose their appetites, a consequence of the salt-free diet which has occasionally been known to cause serious malnutrition."*

*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

03156

RADIUM

(Including Radium Applicators)

For All Medical Purposes

Est. 1919

Quincy X-Ray & Radium Laboratories

(Owned and Directed by a Physician-Radiologist)

HAROLD SWANBERG, B.S., M.D., Director

W. C. U. Bldg. Quincy, Illinois

FOR RENT

A fine opportunity for a general practitioner to establish in a growing neighborhood. I have available an office consisting of a large reception room and six examining rooms adjacent to a drug store. If interested call Pleasure Ridge 7-6550 or write:

Ernest M. Davis
13315 Dixie Highway
Valley Station, Ky.

Help Fight TB



Buy Christmas Seals

Santa's Helpers

...for fifty years!



For a very special purpose, Santa has *millions* of little helpers – Christmas Seals. They give protection and help against tuberculosis—safety and care and hope, and even life itself, to hundreds of thousands of people everywhere. Make this year the best yet. Buy and use Christmas Seals.



50TH Annual Christmas Seal Sale

Because of the importance of the above message, this space has been contributed by

KENTUCKY STATE MEDICAL ASSOCIATION

Doctor Disabled

OFFICE EXPENSE CONTINUES

At last, here is the practical solution to this problem - - - an insurance policy to pay your expenses, with the premium eligible as a Tax Deduction.

Latest Tax ruling provides that premiums on Health and Accident insurance are not deductible unless the policy states that it is for the express purpose of meeting business overhead expenses.

Ask your Accountant or Lawyer about this question and then ask us to explain this coverage.

W. R. LONG & ASSOCIATES
1534 Bardstown Road—Louisville, Ky.

Without obligation to me I would like to have more information on your office expense policy. I am in good health and was

born .....
Month Day Year

Name .....

Address .....

From your patient's viewpoint, Doctor . . .

is this the painful part of the treatment?

It can be, unless your patients know the true facts about the cost of medical care. Parke-Davis is reaching millions of people, in LIFE, SATURDAY EVENING POST and TODAY'S HEALTH, with a consistent advertising campaign whose theme is "prompt and proper medical care can be one of life's biggest bargains."

In addition to the magazine advertisements, Parke-Davis makes folder-reprints available for use in pharmacies. Chances are, a large percentage of the prescriptions you write are being packaged with one of these folders explaining the value of modern prescription medicines—reaching your patients right at the time when they are most conscious of the cost. To date, more than six million of these folders have been ordered by pharmacists.

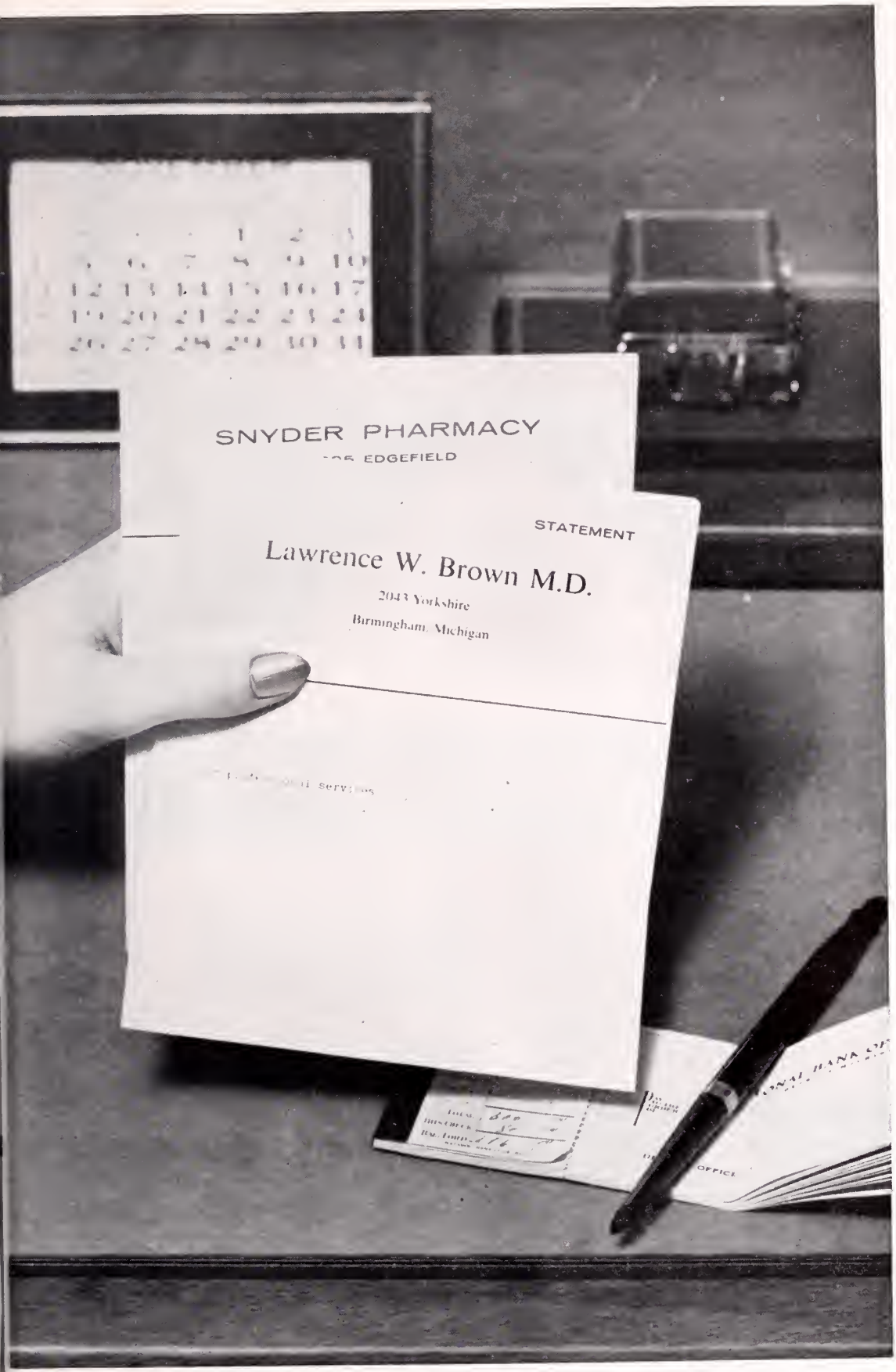
In these advertisements, we strive to present the facts about medical care clearly and unemotionally . . . with the objective of increasing the public's appreciation of why costs and procedures involved are reasonable and fair.



PARKE, DAVIS & COMPAI

Detroit 32, Michigan

If you would like reprints of this Parke-Davis "cost of medical care" series, just drop us a line.


SNYDER PHARMACY
EDGEFIELD
STATEMENT
Lawrence W. Brown M.D.
2043 Yorkshire
Birmingham, Michigan

The Original
Alseroxylon

Rauwiloid®

for the
Somatic
AND
the Psychic Phase of

HYPERTENSION

In addition to its gentle antihypertensive action, Rauwiloid provides psychic tranquility and overcomes tachycardia. Thus Rauwiloid participates in *both* the somatic and psychic phases of therapy for hypertension. Treatment in *all* types of hypertension may begin with Rauwiloid. 80% of mild labile hypertensives require no additional therapy.

Dosage is definite and easy: two 2 mg. tablets at bedtime.

Riker
LOS ANGELES



You are cordially invited to attend

THE THIRD ANNUAL MERRELL SYMPOSIUM

Constructive Medicine in Aging: Cardiovascular Disorders in the Aged

Thursday, January 17, 1957, 9:30 A.M. to 5:00 P.M.
Hall of Mirrors, The Netherland Hilton, Cincinnati, Ohio

PROGRAM

Johnson McGuire, Professor of Clinical Medicine and Director of Cardiac Laboratory, University of Cincinnati College of Medicine, will serve as moderator for the Symposium

K. J. Franklin, The Medical College of St. Bartholomews Hospital, London.
INVESTIGATION OF WHAT IS CONSIDERED NORMAL FOR THE AGING CARDIOVASCULAR SYSTEM

J. Earle Estes, Jr., Mayo Clinic, Rochester, Minnesota.
VENOUS DISORDERS IN OLDER PEOPLE

Walter S. Priest, Associate Professor of Medicine, Northwestern University School of Medicine, Chicago.
ANTICIPATION AND MANAGEMENT OF CARDIAC DECOMPENSATION

Jessie Marmorston, Professor of Experimental Medicine, University of Southern California, Los Angeles.
HORMONAL ASPECTS OF MYOCARDIAL INFARCTION IN FEMALE AND MALE SUBJECTS

Ancel Keys, Professor of Physiology and Director of Laboratory of Physiological Hygiene, University of Minnesota, Minneapolis.
CALORIES AND CHOLESTEROL

Robert W. Wilkins, Professor of Medicine, Boston University School of Medicine, Boston.
DRUG THERAPY FOR HYPERTENSIVE VASCULAR DISEASE IN PATIENTS PAST MIDLIFE

Robert A. Bruce, Associate Professor of Medicine, University of Washington School of Medicine, Seattle.
EVALUATION OF FUNCTIONAL CAPACITY IN PATIENTS WITH CARDIOVASCULAR DISEASE

Edward J. Stieglitz, Consultant in Geriatrics, Veterans Administration and St. Elizabeths Hospital, Washington, D. C.
INTEGRATED UNITY OF THE PATIENT

This Third Annual Merrell Symposium is presented as a service to the medical profession, an important part of Merrell's continuing program of Research in Gerontology.

Merrell
Since 1828

THE WM. S. MERRELL COMPANY New York • CINCINNATI • St. Thomas, Ontario

clinically proved, before introduction, in over 12,000 patients

announcing

*Compazine**

a further advance in psychopharmacology

a true "tranquilizer" with specific action in psychic and psychosomatic conditions

indicated in mental and emotional disturbances — mild and moderate — encountered in everyday practice

available in 5 mg. tablets

minimal side effects

Few drugs have been so thoroughly studied before introduction or introduced with such a substantial background of clinical experience.

In the more than 12,000 cases treated with 'Compazine' here and abroad, and in experimental studies at very high dosage, no blood change or jaundice attributable to 'Compazine' was observed.

Smith, Kline & French Laboratories, Philadelphia 1

*Trademark for proclorperazine, S.K.F.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

This Book is due on the last date stamped below. No **further preliminary notice will be sent.** Requests for renewals must be made on or before the date of expiration.

DUE	RETURNED
DEC 1 3 1957	
SEP 1 4 1960	
APR 24 1963	

A fine of twenty-five cents will be charged for each week or fraction of a week the book is retained without the Library's authorization.